COMMITTEE FOR DEVELOPMENT POLICY
ELEVENTH SESSION

UN Headquarters, New York, Conference Room 6
9-13 March 2009

LIST OF DOCUMENTS

Provisional Agenda of the meeting — CDP2009/PLEN/1

I. Documents below will be distributed at the meeting

A. 2009 triennial review on the list of list developed countries	
2. Report of the EGM on the triennial review of the list of Least Developed Countries	CDP2009/PLEN/2
3. Country Assessment Notes	
a. Papua New Guinea	CDP2009/PLEN/3a
b. Zimbabwe	CDP2009/PLEN/3b
4. Written statements by countries found eligible to graduation in 2006 (pending countries' submission)	
a. Equatorial Guinea	
English	CDP2009/PLEN/4a en
Spanish	CDP2009/PLEN/4a sp
b. Kiribati	CDP2009/PLEN/4b
c. Tuvalu	CDP2009/PLEN/4c
d. Vanuatu	CDP2009/PLEN/4d
5. Written statement by Maldives (pending country's submission)	CDP2009/PLEN/5

B. 2009 Annual Ministerial Review: implementing the internationally agreed goals on Global Public Health	
6. Global Public Health	
a. Addressing health inequalities: the role of international cooperation (background document by the EGM on the 2009 AMR)	CDP2009/PLEN/6a
b. Global Public Health - preliminary draft/summary of background study	CDP2009/PLEN/6b

C. Sustainable development	
7. The Climate Change-Development Nexus: elements towards a CDP-position paper	CDP2009/PLEN/7

D. Global financial turmoil and implications for developing countries	
8. Note by Ricardo Ffrench-Davis (to be confirmed)	CDP2009/PLEN/8
9. The global financial crisis and Eastern Europe (Milica Uvalic) —Revised	CDP2009/PLEN/9
10. Bubbles, busts and bailouts: lessons form the global financial meltdown (UN-DESA Policy Brief No.9)	CDP2009/PLEN/10
11. Monthly briefing on the World Economic Situation and Prospects, No. 5	CDP2009/PLEN/11

II. Documents below will be available only in the password protected website
(Not be distributed at the meeting)

A. 2009 triennial review on the list of list developed countries
Ex-ante impact assessments: - Equatorial Guinea, - Kiribati, - Tuvalu, - Vanuatu Vulnerability profiles: - Equatorial Guinea - Kiribati - Tuvalu - Vanuatu Statistical tables: - Maldives - Samoa

B. 2009 Annual Ministerial Review: implementing the internationally agreed goals on Global Public Health
- Global health partnership: implications for the aid system (J.A. Alonso) - Complementary Comments (J.A. Alonso) - Health inequalities within countries: inequalities among households and groups (F. Stewart and P. Ariana) - Working notes on gender and health: prepared for UNCDP (A. Mama) - Domestic energy and health risks: a note prepared for the CDP (B. Agarwal) - Spousal violence: a serious health concern (B. Agarwal) - Women and health in the Maghrib (F. Sadiqi) - Inequalities of access to health care services and health status in CEE and CIS countries (S. Golinowska with collaboration of A. Sowa) - Health indicators, inequalities in health and economic and social determinants" (January 2009) (N. Speybroeck, consultant) - Health and climate change (J.B. Opschoor)

C. Sustainable development
Development and climate change related financial resources (Hans Opschoor)

D. Global financial turmoil and implications for developing countries
- Massive, globally coordinated fiscal stimulus is needed: going from the drawing board to swift actions (UN-DESA Policy Brief No.11) - World Economic Situation and Prospects 2009

III. Documents available at the back of the meeting room

Handbook on the Least Developed Country Category: Inclusion, Graduation and Special Support Measures

COMMITTEE FOR DEVELOPMENT POLICY
ELEVENTH SESSION

UN Headquarters, New York, Conference Room 6
9-13 March 2009

[CLOSED MEETING]

PROVISIONAL AGENDA
(REVISED 5 MARCH 2009)

Monday, 09 March 2009

10:00–11:00: Inaugural and organizational session

Welcome address by CDP Chairman, Mr. Ricardo Ffrench-Davis

Address by President of ECOSOC, H.E. Ambassador Sylvie Lucas, Permanent Representative of Luxembourg to the United Nations

Address by Under Secretary-General for Economic and Social Affairs, Mr. Sha Zukang

Remarks by DESA/DPAD Director, Mr. Rob Vos

Introduction by CDP Secretary, Ms. Ana Luiza Cortez

Adoption of the agenda and organization of work

11:00-11:15: Coffee/tea break

11:15-13:00: Climate change and Development Nexus

Introduction of the report
Hans Opschoor

13:00-14:00: Lunch

14:00- 15:30: Climate change and development nexus (cont.)

Plenary discussion and recommendations to be forward to ECOSOC

15:30-15:45: Coffee/tea break

15:45-18:00 2009Annual Ministerial Review (AMR) on implementing the internationally agreed goals on Global Public Health

Introduction of the report of the CDP subgroup on global public health
Frances Stuart, Willene Johnson, Jose Antonio Alonso

18:30-20:00: Reception for CDP members and guests

Tuesday, 10 March 2009

9:30-11:00 2009 AMR on Global Public Health (cont.)

Plenary discussion on draft report and recommendations to be forwarded to ECOSOC

11:00-11:15: coffee/tea break

11:15-13:00: 2009 AMR on Global Public Health (cont.)

Plenary discussion on draft report and recommendations to be forwarded to ECOSOC

13:00 -14:30: lunch

14:30-16:00: 2009 Triennial Review of the Least Developed Country category

Introduction of the report by CDP expert group meeting on LDCs: applying the criteria for the identification of LDCs, preliminary results
Patrick Guillaumont and Olav Bjerkholt

16:00-16:15: coffee/tea break

16:15-18:00: 2009 Triennial Review of the Least Developed Country category (cont.)

Plenary discussion on recommendations of the report (countries identified for inclusion)

Wednesday, 11 March 2009

9:30-11:00: Triennial Review of the Least Developed Country category (cont.)

Plenary discussion on recommendations of the report (countries identified for graduation)
11:00-11:15: coffee/tea break

11:15-12:45: 2009 Triennial Review of the Least Developed Country category (cont.)

Plenary discussion on recommendations of the report (countries identified for graduation, overview of graduating and graduated countries)

13:15–14:45 Briefing of delegations on CDP deliberations on the 2009 AMR theme at the Economic and Social Chamber
(implementation of international agreed goals and commitments on global public health)
Frances Stuart and Jose Antonio Alonso

14:30-18:00: Subgroups to draft, revise, amend recommendations to be included in CDP report

Thursday, 12 March 2009

10:00 am – 1:00 pm: Panel discussion on the global financial turmoil and implications for developing countries

Ricardo Ffrench-Davis, University of Chile, CDP
Stephany Griffith-Jones, Initiative for Policy Dialogue, Columbia University
Milica Uvalic, University of Perugia, CDP
Rob Vos, Department of Economic and Social Affairs

13:00 – 14:30: lunch

14:30- 17:30: Subgroups to revise, amend and redraft recommendations to be included in CDP report.

17:30 – 18:00: Draft reports to be circulated to the plenary

Friday, 13 March 2009

9:30 - 11:00: Discussion of CDP work for the 2010
Agenda of work on the 2010 AMR: Implementing the internationally agreed goals and commitments in regard to gender equality and empowerment of women
Other topics to be addressed by CDP during the year

11:00: 11:15: coffee/tea break

11: 15-12:30: Presentation of revised recommendations

12:30- 14:00: lunch

14:00- 15:30: Adoption of the recommendations CDP report

15:30- 15:45: coffee/tea

15:45- 17:00: Working methods, pending issues, other matters and closing of the meeting.

Committee for Development Policy
Expert Group Meeting on the
2009 Triennial Review of the list of least developed countries
United Nations Headquarters,
27-29 January 2009

REPORT OF THE MEETING

I. Objectives of the meeting

The CDP expert group meeting on the least developed countries had the following objectives: (i) to undertake a preliminary review of the list of least developed countries to determine which countries should be added to or graduated from the list of least developed countries in accordance with Economic and Social Council resolution 1998/46 of 31 July 1998, annex I, paragraph 9; (ii) to monitor the development progress of countries graduating from the list of least developed countries as requested by the Council resolution E/2008/12 of 23 July 2008, paragraph 4; and, (iii) to monitor the development progress of countries that have graduated from the category as requested by the General Assembly resolution 59/209 of 20 December 2004, paragraph 12.

The EGM included five Members of the Committee, a representative from ESCAP, and staff members from the CDP Secretariat.

Representatives of Kiribati, Tuvalu, Vanuatu and Equatorial Guinea contributed to the expert group meeting by making oral presentations on their respective countries' views on the possibility of graduation from the LDC category, in accordance with the guidelines adopted in 2007, cf. *Handbook*, p.13

The Expert Group Meeting elected Mr. Patrick Guillaumont as Chairman, and Mr. Olav Bjerkholt as Rapporteur.

The agenda of the meeting and the list of participants, including the delegations from LDCs, are contained in the annex to this report.

II. The identification of least developed countries: the 2009 review

A. Background

The category of Least Developed Country was established in 1971 and for many years after that the question of leaving the category as a result of no longer fulfilling the criteria for inclusion into the category did not arise. The number of LDCs increased from 25 at the outset in 1971 to around 50 at the turn of the century. No countries left the category in this period, apart from Botswana in 1994 after having been found eligible also in 1991. The CDP has worked systematically since the beginning of the 1990s towards establishing precise criteria and procedures for graduation of countries from the LDC category, as well as for inclusion of additional countries. This was pertinent as several

countries among the LDCs achieved considerable progress in their social and economic development. CDP has in this century undertaken triennial reviews of the list of LDCs in 2000, 2003 and 2006 with a forthcoming review in March 2009. At all of these reviews some countries have been found eligible for graduation. No country was, however, graduated until Cape Verde left the category in 2007 after having been found eligible for graduation in 2000 and 2003. Two other countries, Maldives and Samoa, are underway to be graduated in 2011 and 2010, respectively.

The criteria and procedures have been revised and improved several times and endorsed by ECOSOC. Graduation from and inclusion into the LDC category is now well established, and all details relating to this have recently been incorporated in the *Handbook on the Least Developed Country Category: Inclusion, Graduation and Special Support Measures*. The review and monitoring undertaken by the EGM has adhered closely to the established practice. A brief description of the criteria and established procedures follows.

The identification of least developed countries—defined as low-income countries suffering from most severe structural handicaps to growth-- is currently based on three criteria: (a) gross national income (GNI) per capita as an indicator of income generating capacity; (b) the human assets index (HAI) as an indicator of the stock of human assets; and (c) the economic vulnerability index (EVI) as an indicator of economic vulnerability to exogenous shocks. In addition, since 1991 low-income countries with a population exceeding 75 million have not been eligible to be considered for addition to the list, on the grounds that countries with larger populations often have advantages in terms of the potential supply of human capital, as well as offering potentially larger domestic markets.[1]

The EGM recalled that for a country to be included in the category, all three criteria have to be satisfied at given threshold values. In order to ensure that any country graduating from the LDC category should be able to continue and sustain its progress with minimal risk of having its development disrupted or reversed, the following rules have been adopted and applied during previous triennial reviews: i) eligibility for graduation requires a country to fail to meet two, rather than only one, of the three criteria; ii) thresholds for graduation are established at a higher level than those for inclusion; iii) to be recommended for graduation a country has to be found eligible at two successive triennial reviews; and iv) while inclusion is immediate, graduation takes place only after three years, in order to give the country time to prepare itself for a smooth transition from the list.

The CDP further established in 2005 that a sufficiently high level of GNI per capita-- at least twice the graduation threshold--- could be regarded as sufficient to make a country eligible for graduation, even if the country did not meet the graduation threshold for either of the two other criteria. A requirement, however, is that the sustainability of income level be deemed high.

[1] Report of the Committee for Development Planning on the twenty-seventh sessions (22-26 April 1991), Official Records of the Economic and Social Council, 1991, Supplement No. 11 (E/1991/32).

Before the second triennial review in graduation cases a Vulnerability Profile will be prepared by UNCTAD, cf. *Handbook*, p.10. The CDP expressed the view in 2008 that the Vulnerability profile should give an overall background of a country's economy and development situation. In addition, it should compare the values of the indicators used in the criteria with relevant national statistics and further assess other vulnerabilities that the country is facing (such as instability of remittances, dependency on tourism, high infrastructure cost due to geographical conditions, impact of climate change) and furthermore provide comparative data for other low income countries in similar situations.

In 2009 an input for the triennial review will for the first time also comprise an ex ante Impact Assessment prepared by DESA The Impact Assessment will identify the likely consequences of graduation for the country concerned, that is, those potential risks factors, or gains, that the country may face after graduation (*Handbook*, p. 13).

These rules and procedures as set out above were confirmed by CDP at its 10th session[2] and have provided the basis for the current review. CDP gives recommendations on graduations and inclusions. The decision on whether the countries should be graduated is the responsibility of the ECOSOC and, ultimately, the General Assembly, cf. *Handbook*, p.13. Inclusion decisions are also, after recommendations by CDP, taken by ECOSOC but are not effectuated unless they are accepted by the countries, cf. *Handbook*, pp. 9-10.

In applying the criteria, the EGM was in line with earlier practice also guided by the following: the need (a) for flexibility in the application of the criteria, (b) to ensure equal treatment of countries over time (this implies that countries in a similar position vis-à-vis the criteria from one review to the other should be treated equally), (c) to maintain stability in the criteria and in the application of the established procedures so as to ensure the credibility of the process and, consequently, of the list itself,

Flexibility is particularly relevant in situations where country indicators are very close to the inclusion or graduation thresholds (referred to as 'borderline cases'). In these cases, guidance could be given by considering a combination of the structural handicap criteria (HAI and EVI). This flexibility in the application of the criteria in addition to the country assessment notes (inclusion), vulnerability profiles and ex ante impact assessments (graduation) also contributes to ensuring that economic vulnerability is duly taken into account when establishing a country's eligibility for inclusion and graduation, as suggested by ECOSOC (E/2007/35)

With respect to maintaining inter-temporal consistency and equity among countries, the EGM recognized that asymmetries between inclusion and graduation imply that a number of countries already on the list of least developed countries do no longer fulfill the criteria for inclusion. In some cases, countries on the list achieve income levels above the inclusion criteria while at the same time they still have significant structural impediments which preclude them from fulfilling graduation requirements.

[2] Report of the Committee for Development Policy on the tenth session (17-20 March 2008). Economic and Social Council Official records, 2008, Supplement 13 (E/2008/33).

B. Criteria for the identification of the least developed countries

1. Gross national income (GNI) per capita

The initial list of countries to which the criteria for identifying the least developed countries were applied during the 2009 review comprised all developing countries classified by the World Bank as low-income in one of the calendar years 2005-2007. As a result, 60 countries have been retained for consideration during the 2009 review, comprising the 49 current least developed countries and 11 low-income countries which are currently not classified as least developed countries (table 1).[3]

The threshold for inclusion in the present review is a three-year (2005-2007) average GNI per capita of $ 905.[4] With regard to the threshold for graduation, the Expert Group adhered to the CDP recommendation that the graduation threshold be established at 20 per cent above the threshold for inclusion, corresponding to $1,086. As explained above, the higher threshold for graduation is adopted primarily to avoid the possibility that graduating countries could rejoin the category a few years later as a result of short-term fluctuations in their GNI per capita arising from exogenous shocks.[5]

Eight least developed countries currently on the list are above the graduation threshold for this criterion (see table 1). These include the four countries found eligible for graduation for the first time at the 2006 review (Equatorial Guinea, Kiribati, Tuvalu and Vanuatu) and the two countries (Maldives and Samoa) whose graduation has already been decided by the General Assembly.

2. Human Assets Index (HAI)

The HAI should reflect the following dimensions of the state of human capital development: (a) health and nutrition, measured by: (i) the percentage of the population undernourished and (ii) by the under-five child mortality rate; and (b) education, measured by: (i) the gross secondary school enrolment ratio, and (ii) the adult literacy rate.

For the calculation of the HAI, the Expert Group in line with the CDP procedures described in the *Handbook*, pp. 41-47, had the original data transformed into max-min or min-max indices ranging from 0 – 100. Bounds were imposed on extreme outliers to allow for better comparison of values in the distribution and for comparisons of the indicators over time. The HAI is then an unweighted average of the four transformed indicators, cf. *Handbook*, p. 45.

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[3] The low-income developing countries do not comprise any "economies in transition" whose income fell drastically after 1990 but were expected to recover to former income levels. Three of the EITs, Kyrgyzstan, Tajikistan and Uzbekistan,still have an income per capita lower than the low-income threshold of the World Bank and might be reclassified as low income developing countries if still so at the next triennial review. Simulations done with these three countries taken into consideration for the present review show that their inclusion would not have changed the findings on eligibility for inclusion and graduation.

[4] The World Bank's thresholds for low-income countries during these three years were $875, $905 and $935, respectively.

[5] Report of the Committee for Development Policy on its fifth session (E/2003/33).

Table 1. Least developed and other low-income countries criteria used in determining eligibility for least developed country status

Per capita gross national income (United States dollars)			Human assets index (HAI)			Economic vulnerability index (EVI)		
LI	L	Burundi	100.0	LI	L	Somalia	9.4		L	Tuvalu	79.7
LI	L	Dem. Rep. of the Congo	130.0	LI	L	Afghanistan	15.2		L	Kiribati	75.3
LI	L	Liberia	133.3	LI	L	Chad	20.0	LI	L	Liberia	65.5
LI	L	Guinea-Bissau	186.7	LI	L	Sierra Leone	20.4	LI		Zimbabwe	64.3
LI	L	Ethiopia	190.0	LI	L	Burundi	22.1		L	Samoa	64.3
LI	L	Eritrea	196.7	LI	L	Dem. Rep. of Congo	22.6	LI	L	Somalia	62.6
LI	L	Malawi	233.3	LI	L	Niger	22.8		L	Vanuatu	62.3
LI	L	Sierra Leone	236.7		L	Angola	26.0		L	Equatorial Guinea	60.5
LI	L	Niger	266.7	LI	L	Central African Rep.	27.2	LI	L	Guinea-Bissau	60.5
LI	L	Somalia	281.7	LI	L	Mozambique	27.5		L	Maldives	58.2
LI	L	Rwanda	283.3	LI	L	Ethiopia	28.4	LI	L	Solomon Islands	58.0
LI	L	Gambia	286.7	LI	L	Liberia	30.6	LI	L	Laos	57.9
LI	L	Madagascar	296.7	LI	L	Mali	32.6	LI	L	Comoros	56.9
LI	L	Afghanistan	301.0	LI	L	Rwanda	33.0	LI	L	Burundi	56.8
LI	L	Uganda	303.3	LI	L	Burkina Faso	33.2	LI	L	Timor-Leste	56.7
LI	L	Myanmar	306.3	LI	L	Guinea-Bissau	33.8	LI	L	Gambia	56.3
LI	L	Mozambique	306.7	LI	L	Eritrea	36.2	LI	L	Malawi	55.9
LI	L	Nepal	320.0	LI	L	Guinea	37.4	LI	L	Cambodia	55.6
LI		Zimbabwe	340.0	LI	L	Haiti	39.8	LI	L	Eritrea	55.5
LI	L	Togo	350.0	LI		Cote d'Ivoire	40.3	LI	L	Rwanda	55.0
LI	L	Central African Republic	363.3	LI	L	Tanzania, United Rep. Of	40.6	LI	L	Sao Tome and Principe	55.0
LI	L	Tanzania, United Rep. of	373.3	LI	L	Zambia	40.7	LI	L	Chad	53.5
LI	L	Guinea	413.3	LI	L	Senegal	40.7	LI	L	Bhutan	52.9
LI	L	Burkina Faso	416.7	LI	L	Benin	41.1	LI	L	Sudan	52.9
LI	L	Bangladesh	453.3	LI	L	Togo	42.6	LI	L	Zambia	52.8
LI	L	Chad	463.3	LI	L	Gambia	42.6	LI		Mongolia	52.7
LI	L	Mali	470.0		L	Djibouti	44.5	LI	L	Haiti	52.2
LI	L	Cambodia	490.0	LI	L	Madagascar	45.5	LI	L	Uganda	51.9
LI	L	Haiti	490.0	LI	L	Malawi	46.2		L	Djibouti	51.2
LI	L	Lao PDR	510.0	LI	L	Comoros	48.2	LI	L	Sierra Leone	50.7
LI		Ghana	513.3		L	Equatorial Guinea	49.5	LI		Dem. Peo's Rep.Korea	50.2
LI	L	Benin	536.7	LI		Pakistan	49.6		L	Lesotho	49.9
LI		Dem. Peo's Rep.Korea	580.7	LI		Nigeria	50.6		L	Angola	49.8
LI		Kenya	596.7	LI	L	Uganda	51.3	LI	L	Dem. Rep. of the Congo	49.3
LI	L	Zambia	646.7	LI	L	Sudan	51.4	LI	L	Mozambique	48.7
LI	L	Comoros	666.7	LI	L	Yemen	52.1	LI	L	Mauritania	47.1
LI	L	Solomon Islands	683.3	LI	L	Bangladesh	53.3	LI	L	Niger	45.8
LI		Viet Nam	703.3	LI	L	Timor-Leste	54.0	LI	L	Central African Republic	45.1
LI	L	Mauritania	733.3	LI		Papua New Guinea	54.3	LI	L	Yemen	44.9
LI		Papua New Guinea	753.3	LI	L	Mauritania	54.6	LI		Papua New Guinea	44.6
LI	L	Yemen	766.7	LI		Kenya	55.9	LI		Ghana	44.5
LI	L	Senegal	773.3	LI		Zimbabwe	56.3	LI	L	Burkina Faso	43.8
LI		Nigeria	780.0	LI	L	Cambodia	57.8	LI	L	Togo	42.8
LI	L	Sudan	786.7	LI	L	Nepal	58.3	LI	L	Benin	42.5
LI		Pakistan	800.0	LI	L	Bhutan	58.6	LI		Nigeria	42.4
LI	L	Sao Tome and Principe	810.0	LI		India	61.7	LI	L	Mali	42.3
LI		India	836.7		L	Lesotho	61.9	LI	L	Afghanistan	39.5
LI		Côte d'Ivoire	870.0	LI	L	Lao People's Dem. Rep.	62.3	LI	L	Senegal	37.6
	L	Lesotho	940.0	LI		Ghana	63.5	LI	L	Myanmar	37.4
LI		Mongolia	1033.3	LI	L	Solomon Islands	64.1	LI	L	Madagascar	37.2
	L	Kiribati	1048.0	LI	L	Myanmar	66.0	LI	L	Nepal	33.6
	L	Djibouti	1050.0	LI		Dem. People's Rep. Korea	71.2	LI	L	Ethiopia	32.0
LI	L	Timor-Leste	1070.0	LI	L	Sao Tome and Principe	72.1	LI		Côte d'Ivoire	31.5
LI	L	Bhutan	1486.7		L	Vanuatu	72.3	LI	L	Tanzania, United Rep. of	31.0
	L	Vanuatu	1736.7	LI		Mongolia	80.8	LI	L	Guinea	27.9
	L	Angola	1963.3	LI		Viet Nam	83.2	LI		Viet Nam	26.5
	L	Samoa	2240.0		L	Maldives	87.5	LI	L	Bangladesh	23.2
	L	Tuvalu	2544.3		L	Kiribati	87.6	LI		Pakistan	22.3
	L	Maldives	2940.0		L	Tuvalu	88.4	LI		Kenya	18.4
	L	Equatorial Guinea	8956.7		L	Samoa	92.2	LI		India	17.5
		Cape Verde	2180.0			Cape Verde	81.9			Cape Verde	48.1

In line with established practice in previous reviews, the HAI threshold for inclusion is the third quartile in the ranking of the 60 countries as given in table 1, i.e. between countries ranked as no. 15 (India) and 16 (Bhutan), rounded to the nearest integer. As in the 2003 and 2006 reviews, the threshold for graduation was established at 10 per cent above the inclusion threshold. Thus, the threshold for inclusion in the list of least developed countries at the 2009 triennial review is a HAI value of 60, while the threshold for graduation is 66.

3. Economic vulnerability index (EVI)

The vulnerability of a country that is considered in the identification of the least developed countries is structural economic vulnerability. For this purpose, the EVI should reflect a risk posed to a country's development by exogenous shocks, the impact of which depends on the size of the shocks, and on essential structural characteristics that determine the extent to which the country would be affected by such shocks.

Thus EVI is constructed as a composite index with one part representing the exposure to shocks, while the other part is a shock index. The exposure to shocks sub-index comprises three components representing smallness, location, and a structural index, the latter consisting of two indicators. The shock index comprises sub-indices of natural shocks (two indicators) and trade shocks. The seven indicators are:

Exposure index:
(i) Population (smallness);
(ii) Remoteness (location);
(iii) Merchandise export concentration (structural index);
(iv) Share of agriculture, forestry, and fisheries in GDP (structural index);

Shock index:
(v) Homelessness due to natural disasters (natural shock index);
(vi) Instability of agricultural production (natural shock index); and,
(vii) Instability of exports of goods and services (trade shock index).[6]

In the calculations of the EVI, the Expert Group had the indicators transformed in a similar way as for the HAI indicators into indices ranging from 0 – 100 and a weighted average was calculated to produce the EVI, cf. *Handbook*, pp. 42-43.

In keeping with the previous reviews, the EVI threshold for inclusion is the first quartile in the ranking of the 60 countries, as given in table 1. As in the case of the HAI, the Expert Group used a difference of 10 percent between thresholds for inclusion and graduation. The threshold for inclusion in the 2009 triennial review is thus 42, while the threshold for graduation is 38.

[6] E/2005/33.

C. Eligibility for inclusion and graduation

The preliminary 2009 review of least developed countries was conducted by the Expert Group in line with the general principles for the identification of least developed countries as recommended by the Committee in its review of the criteria in 2008.[7]

(a) Countries to be considered for inclusion

The Expert Group identified two countries – Papua New Guinea, and Zimbabwe – that meet all three criteria for inclusion in the list of least developed countries as shown in the table below:

Country\Threshold	GNIpc < $905	HAI < 60	EVI > 42
Papua New Guinea	$753	54	45
Zimbabwe	$340	56	64

Source: table 1

The Expert Group observed that both countries were found eligible for inclusion at the 2006 review. At that time both declined joining the category.

Papua New Guinea argued in 2006 that CDP's recommendation came at a time when the country was experiencing strong economic growth and political stability, and questioned the reliability of the indicators used by the Committee in assessing the country's development progress. While noticing some progress by the country since 2006 in relation to the inclusion criteria, the Group remarked that Papua New Guinea meets the eligibility criteria for inclusion in the list of LDCs. Thus, it requested DESA, in accordance with the procedures for inclusion in the list of LDC adopted by the CDP at its ninth session, to prepare a country assessment note for presentation to the plenary session. It also asked DESA to notify the Government of Papua New Guinea of this preliminary finding and of its further consideration by the Committee at its plenary meeting.

In the case of Zimbabwe, the country argued in 2006 that its low GNI per capita was a result of temporary economic setback caused by the sanctions imposed by some Western countries and successive years of drought since 2000. It also noted that the country had effective health and educational systems, implying that human assets were not in decline. It further noted that "economic growth statistics" often failed to capture "the growth and vital contribution of the non-traditional sectors of agro-business and the small-scale informal sector in the provision of goods and services." The committee found in 2006 that the deterioration of social and economic conditions in Zimbabwe had resulted in structural handicaps sufficient to qualify for inclusion. The assessment was reinforced at the current review. The EGM thus requested DESA, in accordance with the procedures for inclusion in the list of LDCs adopted by the CDP at its ninth session, to prepare a country assessment note for presentation to the plenary session. It also asked DESA to

[7] E/2008/33.

notify the Government of Zimbabwe of this preliminary finding and of its further consideration by the Committee at its plenary meeting.

(b) Countries to be considered for graduation

(i) Non-graduated countries found eligible at the 2006 review

In 2006, the Committee found Equatorial Guinea, Kiribati, Tuvalu and Vanuatu eligible for graduation. These countries were thus reconsidered as to whether they qualified for graduation. When a country meets the graduation criteria for the second consecutive time, the Committee – after considering all relevant quantitative and qualitative information at its disposal – may recommend the country for graduation in its report to the ECOSOC, cf. *Handbook*, p.13.

The Expert Group considered the ex ante impact assessments prepared by DESA (available at http://www.un.org/esa/policy/devplan/profile/impact_assessments.html) and vulnerability profiles prepared by UNCTAD on the four countries and also took into account a report prepared by the Government of Vanuatu on its LDC status.

Before reviewing the four countries the EGM heard oral statements by delegations for each of the four countries and had the opportunity for a brief exchange of views.

Equatorial Guinea:
Equatorial Guinea had in 2005-2007 a GNI per capita of $ 8,957, relative to the graduation threshold of $ 1,086 (with GNI per capita in 2007 equal to $ 12,860). The HAI was low, only 49, relative to the graduation threshold of 66 and with an EVI of 61 relative to the graduation threshold of 38. Equatorial Guinea thus does not fulfill the graduation requirements neither for HAI nor EVI but has an income level more than eight times the graduation threshold, which suggests that it is eligible for graduation.

The source of income is completely dominated by revenues from petroleum extraction. The amount of reserves and the reasonable expectations of oil prices indicates that a high income level, relative to the low-income threshold, is sustainable in the foreseeable future. As indicated in the ex-ante impact assessment, graduation from the list of least developed countries is not expected to have a significant impact on the country's development prospects as most of its exports already enter markets duty free under the MFN treatment.

The delegation from Equatorial Guinea pointed to weaknesses in the data used in the EVI, not least that the population was substantially higher than the number used. This would directly affect the assessed level of GNI per capita. The details will be looked into by DESA. The delegation also indicated its concern about losing access to technical cooperation and other forms of capacity building assistance. In the EGM's view, this concern is unwarranted. As an LDC, Equatorial Guinea is fully entitled to the transition strategy support by the UN system as per resolution 59/509 of the General Assembly.

The EGM concluded that Equatorial Guinea was qualified for graduation and the Committee may wish to recommend the country for graduation from the list of LDC.

Kiribati:
Kiribati had in 2005-2007 a GNI per capita of $ 1,193, thus about 10 % higher than the graduation criterion of $ 1,086. The HAI for Kiribati was calculated to be 88, thus well above the graduation criterion of 66. EVI for Kiribati was found to be 75, the second highest after Tuvalu and above the graduation criterion of 38.

Kiribati thus seemed to fulfill two of the criteria as required for eligibility for graduation while it remains one of the most vulnerable countries among the 60 countries on the reference list, see table 1.

The delegation from Kiribati was helpful in clarifying various issues relating to the country's situation. It also presented alternative, slightly lower values for GNI per capita 2005-2007. These have been corroborated and checked against data made available at the UN DESA Statistics Division's National Account database. According to the latter, the average GNI per capita of Kiribati for the period 2005-2007, as calculated by DESA was $1048 (already reflected on table 1). Thus, the EGM found that Kiribati was not eligible for graduation as it does not fulfill the income criterion.[8]

Tuvalu:
Tuvalu had in 2005-2007 a GNI per capita level of $ 2,544, as compared to the graduation threshold of $ 1,086. The HAI was found to be 88, thus well above the graduation threshold level of 66.[9] The EVI was found to be 80, far above the graduation threshold level of 38. Tuvalu thus fulfills two of the graduation criteria as required for eligibility for graduation. Its income level is very high for an LDC, while its vulnerability as measured by the EVI is the highest on the list of 60 countries, see table 1.

Tuvalu is an extreme case for several reasons. It is a tiny archipelagic island group with a population of just above 10,000. It has an amount of ODA relative to GNI which seems to surpass that of all other countries. Tuvalu has in addition to ODA, other sources of income, not generated by its domestic productive sectors and which are volatile (remittances, fishing license fees, dotcom revenues), that had resulted in a high income level with almost negligible primary income generated by productive domestic economic sectors. Hence, the GNI per capita did not seem to correspond to the country's existing productive capacity. The group also noticed that graduation from the list of least developed countries does not seem to have an impact on the support measures currently received by the country. Export revenues are very limited and mostly of products facing tariff free entry under MFN treatment while ODA inflows do not seem to accrue to the country due to its LDC status.

On the basis of the criteria values, Tuvalu is found eligible and thus qualified for graduation. However, the additional information considered, both the extreme

[8] The EGM also noted that Kiribati has very high ODA as a share of GNI, surpassed only by Tuvalu. This feature is problematic with regard to considering GNI per capita as a measure of income generating capacity of the economy.
[9] The EGM noted a small discrepancy regarding Tuvalu's secondary school enrolment between UNESCO (84.4%) and the Vulnerability profile (69%).

"smallness" and the lack of productive activities, questions the possibility of a sustainable growth path. Thus, the Committee may wish not to recommend Tuvalu for graduation at the present review, but to re-examine the case of Tuvalu at the next triennial review in 2012.

Vanuatu:
Vanuatu had in 2005-2007 a GNI per capita level of $ 1,737, as compared to the graduation threshold of $ 1,086 (both expressed in current US dollars). The HAI was found to be 72, thus well above the threshold level of 66. The EVI was found to be 62, well above the graduation threshold level of 38. Vanuatu thus fulfills two of the graduation criteria as required for eligibility for graduation. Its income level is about 50 per cent higher than the graduation threshold, while its vulnerability as measured by the EVI is among the highest on the list of 60 countries, see table 1.

The delegation from Vanuatu contested the values used for the literacy rate and indicated that the ex ante impact assessment in its survey of Vanuatu's trade mistakenly considered products not exported by the country. DESA will look into these issues. In its vulnerability profile, UNCTAD argued that the literacy rate was lower than measured by UNESCO, and, as noted by the expert group, it could not be ruled out that the difference was large enough to bring the HAI below the graduation threshold. Thus, the Group requested the Secretariat to consult with UNESCO to verify the data used in the calculations of HAI.[10]

The EGM noted that a comparison by a combination of structural handicap criteria (HAI and EVI) indicates that Vanuatu has a more severe structural handicap than the three graduated and graduating countries. The EGM also remarked that the average rate GDP per capita growth (calculated in national currency under constant prices) has been negligible over the period 2000-2007. The low average growth rate during the period was due to a contraction in 1999-2002 followed by a recovery in 2003-2007. The group also acknowledged the main conclusions of the ex-ante impact assessment that indicated exports of copra already enjoy duty free entry in the country's major export markets while several bilateral donors indicated that LDC status was not a major consideration in their partnership with the country.

On the basis of available data, Vanuatu fulfills the graduation criteria for the second consecutive time. In view of the doubts raised about the literacy level, as one of the education components of HAI, and, even more, about the sustainability of the improvements registered by Vanuatu the Committee may wish not to recommend the country for graduation, but to re-examine the case of Vanuatu at the next triennial review in 2012.

[10] Note by Secretariat. After the end of the meeting, the explanation of the discrepancy has been given by UNESCO as follows. The literacy rate referred to by UNCTAD comes from a literacy assessment survey, while the higher figure prepared by UNESCO (and used in the HAI) measures literacy in a simpler way dichotomously by self-declaration, as typically collected by a census. The aim of UNESCO is to provide data users with cross-national comparative dichotomous literacy figures, as indeed used for the calculation of HAI for all LDCs.

(ii) Other countries meeting the graduation criteria in 2009

No other LDC countries were found eligible. The group noted that Myanmar—while not considered for graduation— seems to be the country closest to meet the criteria, but in a way that sets it apart from countries considered in previous reviews. At $306, the country's GNI per capita is less than one third of the income graduation threshold. At the same time, Myanmar meets the EVI criterion, while its HAI value is on the borderline with regard to the graduation threshold.

D. Recommendations:

The Group recommends that Papua New Guinea and Zimbabwe be added to the list of LDCs and that Equatorial Guinea is graduated from the list.

III. Monitoring the development progress of countries graduating from the category

Economic and Social Council resolution 2008/12 requests the Committee to monitor the development progress of countries graduating from the list of least developed countries and to include its findings in its annual report to the Council. In response to the ECOSOC resolution, the EGM reviewed the development progress of Maldives and Samoa in conjunction with the 2009 triennial review of the list of least developed countries.

Maldives has recovered strongly from the tsunami disaster and now has the second highest GNI per capita and the fourth highest HAI score among the reference group composed of 60 least developed and low-income developing countries. Compared to the review in 2006, Maldives' GNI per capita increased from $2,320 to $2,940 while its HAI value further improved in relation to the graduation threshold. Looking at the larger group of 130 developing countries, Maldives now ranks number 39, up from number 52 in 2006. Economic vulnerability however remains high and became more acute over the period. The country's EVI is estimated at 58 at the 2009 review (51 in the 2006 review), compared to a graduation threshold of 38 (also in 2006). The deterioration of the country's EVI is largely due to a weaker performance under the "homelessness" component which was the result of the tsunami of December 2004.

Samoa has the fourth highest GNI per capita and the highest HAI score among the reference group of 60 countries. As compared to the review in 2006, the GNI per capita increased from $1,597 to $ 2,240, while the country's HAI currently place the country number 22 within a group of 130 developing countries. The country remains economically vulnerable but there is no noticeable deterioration in its relative vulnerability as indicated by the EVI. Both in the 2006 and 2009 reviews, the country's EVI scored 64 compared with a graduation threshold of 38 (also in both reviews).

On the basis of this information, the EGM noted the continued positive development progress of Maldives and Samoa. The group also noted that both countries are to graduate in the near future (Maldives in 2011 and Samoa in 2010) and reiterate the importance of

developing their smooth transition strategy with the support of their respective development partners.

IV. Monitoring the progress of graduated countries: the case of Cape Verde

In its resolution 59/209, the General Assembly has requested the CDP to continue to monitor the development progress of countries that have graduated from LDC status.[11] The CDP will report on the findings of the monitoring exercise to ECOSOC as a complement to the triennial review of the list of LDCs.

At its tenth session in 2006, the Committee established that the main purpose of the monitoring is to assess any signs of deterioration in the development progress of the country under consideration, during the post-graduation period, and bring it to the attention of ECOSOC as early as possible. It further decided that the monitoring would cover a relatively small set of variables to be assessed beyond the country's performance on the CDP criteria.

The three criteria used by the Committee for the identification of LDCs indicate continued progress achieved by Cape Verde (see table 1): Average GNI per capita grew from $1487 since the last review in 2006, to an average of $2180 for the 2009 review (substantially above the graduation threshold). The human assets index (HAI) remains high and far above the graduation threshold. The economic vulnerability index (EVI) improved in relation to the countries that were reviewed in 2009: Cape Verde's EVI is now lower than about half the countries included in the 2009 review.

On the base of available data, Cape Verde continues to progress towards meeting some of the Millennium Development Goals (MDG) and, according to the World Bank, is on target to meet most MDGs by 2015. Addressing food insecurity which affects a significant part of the population is an important element in achieving the MDG target of halving between 1990 and 2015 the proportion of people who suffer from hunger. Also, meeting the MDGs related to sanitation and infrastructure may be more difficult to attain due to the large investment needed to achieve improvements. Poverty remains significant[12], but if the country is able to sustain its robust rate of growth, it is estimated that poverty may be halved of its 1990 value by 2015.[13]

The country's economic growth in recent years has been robust. The economy has been supported by large inflows of official development assistance, remittances from nationals living abroad and, more recently, by a fast growing tourism sector and the related foreign direct investment. Tourism represents a large share of GDP. As Cape Verde's economy becomes more dependent on tourism income and its export base remains narrow, a reduction in demand for tourism from foreign markets during a global economic

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[11] General Assembly Resolution A/RES/59/209.

[12] Republic of Cape Verde, Ministry of Finance and Public Administration, General Planning Directorate. "Growth and Poverty Reduction Strategy Paper - II", May 2008.

[13] World Bank Country Brief Cape Verde. Accessed at http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/CAPEVERDEEXTN/0,,menuPK:349633~pagePK:141132~piPK:141107~theSitePK:349623,00.html on December 20, 2008.

downturn will be felt throughout the entire economy. Moreover, Cape Verde remains dependent on imports and is vulnerable to external economic shocks caused by changing prices, particular for food and fuel. The economic impact of the global financial crisis is likely to become a severe challenge for the small and rather exposed economy of Cape Verde.

In preparation of Cape Verde's graduation from the list of least developed countries, the Government and its development partners set up a donor support group (Grupo de Apoio à Transição- GAT) in 2006, to prepare a transition strategy to adjust to the eventual phasing out of the support measures associated with the membership on the LDC list. The GAT has met 7 times. Its latest meeting on 18-19 January 2009 focused particularly on the diagnostic trade integration study (DTIS) of the Enhanced Integrated Framework for Trade related technical assistance (EIF) and measures on how to achieve "Cape Verde's insertion in the global economy" as summarized in the Priority Action Matrix.

Following the country's graduation, the EU extended its Everything But Arms (EBA) preferences to the country for a transition period of three years. In 2008 Cape Verde joined the WTO.

In all, the EGM concluded that Cape Verde's development progress so far has been very satisfactory. The country, however, remains economically vulnerable and sustained efforts are needed to achieve success in the structural transformation and upgrading of the economy. The group also noted that in view of the country's track record of positive performance, together with its enduring vulnerabilities, the international community should continue to support Cape Verde's development. In this regard, Cape Verde should be able to access Tier 1 and Tier 2 of the EIF (or equivalent resources) as part of the recommended smooth transition measures in favour of recently graduated LDCs.

The next monitoring review of Cape Verde by the Committee will take place in 2012.

ANNEX 1. LIST OF PARTICIPANTS FOR THE EGM ON LEAST DEVELOPED COUNTRIES, 27-29 JANUARY 2009.

Name	Title	Organization
Mr. Albert Binger	CDP member	
Mr. Olav Bjerkholt	CDP member	
Mr. Patrick Guillaumont	CDP member	
Mr. Philippe Hein	CDP member	
Ms. Suchitra Punyaratabandhu	CDP member	

Mr. Rob Vos	Director of DPAD, DESA	UN
Ms. Ana Cortez	Chief of CDP,DPAD, DESA	" "
Mr. Roland Mollerus	Economic Affairs Officer, CDP, DPAD, DESA	" "
Mr. Hiroshi Kawamura	Economic Affairs Officer, CDP, DPAD, DESA	" "

Syed Nuruzzaman	EAO, Special Unit on countries with Special Needs	ESCAP

Hon. Lotoala Metia	Minister for Finance and Economic Planning	Tuvalu
Mr. Aunese Simati	Adviser and Permanent Secretary for Finance and Economic Planning	" "
HE Mr. Afelee Pita	Permanent Representative to the UN	" "

Hon. Sela Molisa	Minister of Finance and Economic Management	Vanuatu
Mr. Augustine Garae	First Political Advisor, Ministry of Finance and Economic Management	" "
Mr. Simeon Athy Malachi	Director-General to the Prime Minister Office	" "
HE. Donald Kalpokas	Permanent Representative to the UN	" "
HE. Mr. Roy M. Joy	Ambassador to the European Union	" "
Mr. Odo Tevi	Governor, Reserve Bank of Vanuatu Government	" "
Ms. Evelyn Adams	Second Secretary, Permanent Mission to the UN	" "

Ms. Teea Tira	Secretary for Finance and Economic Planning	Kiribati
Mr. Tebao Awerika	Deputy Secretary for Foreign Affairs and Immigration	" "
Mrs. Kurinati Tiiroa	Senior Economist, Ministry of Finance and Economic Planning	" "

Jose-Domingo Ndong Bakale	D.G. Gabinete del Ministro de Hacienda y Presupuestos	Equatorial Guinea
Gabriel Juan Ondo Matogo	First Secretary, Permanent Mission of EQ to the UN	" "
Bonifacio Mitogo Bindang	Director-General of Int'l Cooperation Ministry of Foreign Affairs, International Cooperation and Francophone	" "

Observers to the meeting: *Sandagdorj Erdenebileg, Chief, Policy Development, Coordination Monitoring and Reporting Service, OHRLLS*

Annex 2. Agenda of Committee for Development Policy Expert Group Meeting on the Review of the list of Least Developed Countries

(New York, 27-29 January 2009)

TIME	AGENDA ITEM	DOCUMENTATION
	TUESDAY 27 January	
9:30- 10:00	Adoption of the agenda and organization of work	
10:00-11:00	Examination of the new set of data for the identification of least developed countries: 1. Gross National Income (GNI) per capita 2. Human Assets Index (HAI) 3. Economic Vulnerability Index (EVI)	2009 GNI per capita, HAI and EVI data (CDP09/EGM/02). GNI comparison 2006-2009 reviews (CDP09/EGM/03). HAI comparison 2006-2009 reviews (CDP09/EGM/04). HAI indicators 2009 review (CDP09/EGM/05). EVI comparison 2006-2009 reviews (CDP09/EGM/06). EVI indicators 2009 review (CDP09/EGM/07).
11:00-11:15	Coffee/tea break	
11:15-12:30	Thresholds and implications – candidates for inclusion and graduation	
12:30-2:00	Lunch break	
2:00-3:00	Discussion on new set of data and conclusions on countries recommended for inclusion	
3:00-3:30	Country assessment notes for countries recommended for inclusion	Content of assessment notes for countries recommended for inclusion (CDP09/EGM/08)
3:30-3:45	Coffee/tea break	
3:45-4:45	Preparations for oral statements from countries found eligible for graduation	
4:45-5:30	Impact assessment and Vulnerability profile of Equatorial Guinea	Impact assessment Equatorial Guinea (CDP09/EGM/10); Vulnerability profile Equatorial Guinea (CDP09/EGM/11).
5:30-6:00	Outline draft report of the expert group meeting	Outline of the report of the Expert Group Meeting (CDP09/EGM/22).
6:15	Cocktail	

TIME	AGENDA ITEM	DOCUMENTATION
WEDNESDAY 28 January		
9:30- 10:30	Impact Assessment and Vulnerability profile of Kiribati	Impact assessment Kiribati (CDP09/EGM/12); Vulnerability profile Kiribati (CDP09/EGM/13).
10:30-11:15	Oral statement from Equatorial Guinea	
11:15-11:30	Coffee/tea break	
11:30-12:15	Oral statement from Kiribati	
12:15-12:30	Recommendations on Equatorial Guinea and Kiribati	
12:30-1:30	Lunch break	
1:30-2:30	Impact Assessment and Vulnerability profile of Tuvalu	Impact assessment Tuvalu (CDP09/EGM/14); Vulnerability profile Tuvalu (CDP09/EGM/15).
2:30-3:15	Oral statement from Tuvalu	
3:15-3:30	Coffee/tea break	
3:30-4:30	Impact assessment and Vulnerability profile of Vanuatu	Impact assessment Vanuatu (CDP09/EGM/16); Vulnerability profile Vanuatu (CDP09/EGM/17); LDC Status Report of Vanuatu (CDP09/EGM/18).
4:30-5:15	Oral statement from Vanuatu	
5:15-6:00	Recommendations on Tuvalu and Vanuatu	

TIME	AGENDA ITEM	DOCUMENTATION
THURSDAY 29 January		
9:30- 10:45	Monitoring development progress of graduating and graduated countries from the list of LDCs (Maldives, Samoa and Cape Verde)	Draft paragraph on monitoring the progress of graduating countries – Maldives and Samoa (CDP09/EGM/20 Draft report for monitoring the progress of graduated countries – Cape Verde (CDP09/EGM/21)
10:45-11:00	Coffee/tea break	
11:00-12:30	Recommendations and drafting of the report	
12:30-2:00	Lunch break	
(1:15-2:45)	(briefing on the LDC Handbook)	
2:00-3:45	Drafting of report	
3:45-4:00	Review of draft report	
4:00-5:30	Redrafting of report	
5:30-5:45	Timeline for approval of final draft	

Papua New Guinea: Country Assessment Note (February 2009)

Summary

During the period 2006 – 2008, Papua New Guinea enjoyed strong economic growth mainly driven by high prices for the country's major mineral export commodities. Prudent monetary and fiscal policies contributed to improved macroeconomic stability, including low to moderate inflation, fiscal and current account surpluses, and a declining debt-to-GDP ratio. However, the country continues to face enormous structural challenges as half of the population is estimated to live below the national poverty line and progress towards the Millennium Development Goals (MDGs) has been very slow. A complex network of geographic, economic, political and social factors hampers Papua New Guinea's development prospects. Most importantly, the population is organized in small, fragmented social groups with strong traditions and a weak sense of national identity. The vast majority of the population makes a living outside the formal employment sector through subsistence farming, where yields are often reduced by difficult terrain and vulnerability to pests and climatic events.

Background

In 2007, the CDP decided that if a country is preliminarily found eligible for inclusion in the LDC list by the expert group preparing for the triennial review, DESA would prepare a country assessment note for the plenary session of the Committee. The assessment note should corroborate the basis for the finding of eligibility from statistical evidence and incorporate other relevant information. Particular consideration should be given to the reasons for recent deterioration of economic and social conditions in the country in order to determine whether the deterioration is due to structural or transitory factors. Assessment notes will be transmitted to the country (prior to the plenary meeting), which will have the opportunity to produce a written statement for the plenary meeting, including the possibility of expressing its objection in principle to being added to the list of least developed countries.

According to the preliminary triennial review of the list of the Least Developed Countries undertaken by the expert group meeting of the Committee for Development Policy on 27-29 January 2009, Papua New Guinea satisfied the three the criteria for inclusion (income, human asset index (HAI) and economic vulnerability index (EVI)) in the LDC category. The country was also found eligible for inclusion at the 2006 triennial review (see table 1 below) but had opted not to join the category. In the country's view, recommendation came at a time when the country was experiencing strong economic growth and political stability. Among other issues, the country also indicated that the EVI did not capture

major economic, social and cultural components of development of PNG, while HAI data did not reflect latest accomplishments by the country.[1]

Table 1
Papua New Guinea: 2006 and 2009 triennial review of the list of LDCs

Criteria	GNI per capita (US$)	Human Asset Index	Economic Vulnerability Index
2006 Triennial review			
Inclusion threshold	< 745	< 58	> 42
Country's values	527	54	44
2009 Triennial Review (preliminary results)			
Inclusion threshold	< 905	< 60	> 42
Country's values	735	54	45

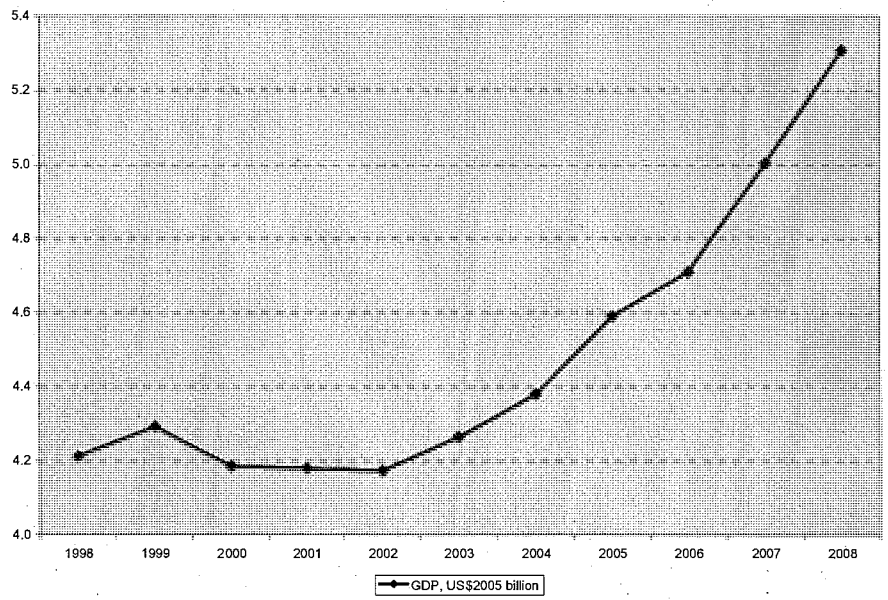
Source: Committee for Development Policy report on the eighth session (20-24 march 2006) Economic and Social Council Official records, 2006, Supplement 13 (E/2006/33) and UN DESA.

Recent economic performance

After a having contracted for 3 successive years—which were preceded by volatile growth—Papua New Guinea's economy recovered after 2003 (see figure 1), with annual real GDP growth averaging about 4 per cent during the period 2003-2008. Economic growth accelerated to 6.2 per cent in 2007 and is estimated at 6.1 per cent in 2008 as the country benefited from strong global demand and high prices for its mineral export commodities.[2] Crude oil, gold, and copper account for approximately 80 per cent of total exports. In addition, agricultural production rebounded from a drought in 2006 and the service sector experienced strong growth as telecommunications, trade, banking, and real estate expanded rapidly. Per capita gross national income (GNI) in Papua New Guinea declined from $1,130 in 1994 to a low of $500 in 2003 (measured by the Atlas method). The subsequent economic recovery resulted in a significant increase in GNI per capita, which stood at $850 in 2007 and is anticipated to have surpassed $900 in 2008.[3]

[1] Statement by Robert Guba Aisi, Ambassador and Permanent Representative of Papua New Guinea to the United Nations on Agenda item 13(a): Review of the Report of the Committee for Development Policy on its ninth session. General Segment of the 2007 Substantive Session on the ECOSOC, 23 July 2007.
[2] Growth rates of real gross domestic product are taken from the UN WESP database.
[3] Average GNI per capita for the period 2005 – 2007 is $753, up from $527 for the period 2002 -2004.

Figure 1.
Papua New Guinea; Gross Domestic Product 1998-2008 (US$2005 billion)



Source: UN DESA World Economic Situation Prospects database

The fiscal balance posted a healthy surplus in recent years mainly owing to strong growth in tax revenues. While part of the windfall revenues from the mining sector has been set aside to meet social and infrastructure needs, the government has also reduced the level of public debt. External debt as a share of GNI fell from 88 per cent in 2002 to 33 per cent in 2006 and this positive trend continued in 2007 and 2008.[4] In line with global trends, inflation in Papua New Guinea rose from 1 per cent in 2007 to an estimated 10 per cent in 2008. However, inflationary pressures are expected to ease in 2009 since the global economic downturn has led to sharply lower international commodity prices.

Overall, the Government of Papua New Guinea has succeeded in achieving macroeconomic stability in recent years and in creating an economic environment that is more conducive to investment and growth. Yet, the economy continues to depend to a large extent on global demand for its main export commodities. As a consequence, the structural weakness of the economy reinforces the wide fluctuations in GDP growth.

Commodity booms however fade and the country continues to face constraints to growth in part due to its difficult topography which makes the provision of infrastructure and services difficult. In fact, as commodity prices have fallen recently and are expected not to recover in the short to medium term, economic growth in Papua New Guinea is forecast to drop below 5 per cent in both 2009 and 2010. Given annual population growth

[4] The WDI database does not yet provide external debt to GNI ratios for 2007 and 2008.

of approximately two per cent, growth is likely to fall significantly short of what is needed to reduce poverty and to ensure faster progress towards the Millennium Development Goals.

Structural handicaps to economic growth and development

Despite the recent recovery of economic growth, Papua New Guinea suffers from serious structural vulnerabilities that pose barriers to development, including widespread poverty and a relatively low level of human development.

Poverty

The World Bank estimates that 53.8 per cent of the population lived below the national income-poverty line in 2005, up from 37.5 per cent in 1996.[5] When the international "dollar-a-day" poverty line was applied instead, 39.6 per cent of Papua New Guineans were classified as poor in 2005, compared to 24.6 per cent in 1996. The main factor underlying the massive increase in income poverty has been a contraction of economic activity during that period, coupled with high population growth. Between 1995 and 2004, GDP growth was negative in six out of ten years, resulting in a decline of mean per capita consumption by 31 per cent.[6] Over the same period, inequality measured by the Gini coefficient remained constant.

Poverty in Papua New Guinea is predominantly a rural phenomenon. Poverty incidence rates in rural areas are about three times higher than urban rates, and it is estimated that in 1996 about 94 per cent of the nation's poor lived in rural areas.[7] In addition, rural poverty is generally considered more severe than urban poverty. The majority of rural poor depends on subsistence agriculture and lacks access to basic services, markets, and infrastructure. As a result, practically all socio-economic indicators are significantly worse in rural areas. Given the country's mountainous and rugged terrain, poverty is to some extent related to natural and environmental constraints. However, the failure of the state to improve infrastructure and public services remains a key factor for the decade-long trend of deteriorating poverty indicators.

Health

In the 2006 Human Development Index (HDI), Papua New Guinea ranked 149th out of 179 countries. Health indicators are generally poor and have not improved significantly during the past two decades. Life expectancy at birth has stagnated at 57 years since 1997. The under-five mortality rate declined from 94 per 1,000 in 1990 to 73

[5] Data and information on poverty are mainly taken from the World Bank's "Poverty Assessment Report" for Papua New Guinea (2004). The national poverty line corresponds to a nutritional norm of 2,200 calories per adult equivalent and also allows for basic nonfood expenditure.

[6] Per capita gross national income measured by the Atlas method is taken from the World Bank's World Development Indicators (WDI) online database.

[7] J. Gibson and S. Rozelle, Poverty and Access to Infrastructure in Papua New Guinea, 2002.

in 2006, but the country is unlikely to achieve the MDG target of reducing the rate by two thirds by 2015.[8]

As in the case of income poverty, the rural-urban gap in health is very wide. According to estimates for the year 2000, under-five mortality in rural areas was almost three times as high as in urban areas. Lack of adequate facilities and health personnel is among the key factors for the poor state of rural health. While consistent data over time are limited, some indicators suggest that the gap has widened during the period of economic contraction, mainly as a result of deteriorating services. Papua New Guinea also suffers from a generalized HIV/AIDS epidemic. The average prevalence rate has increased rapidly during the past decade and was estimated at 1.3 per cent of the adult population in 2006. While known infections involve almost equal numbers of men and women, the number of infected young women is rising fastest. Without comprehensive and effective interventions, the prevalence rate may increase to 10 per cent of the adult population by 2025.[9]

Education

Papua New Guinea's educational sector faces immense challenges as the country's quantitative and qualitative indicators remain very poor. Gross primary school enrollment is estimated to have fallen from 65 per cent in 1991 to 55 per cent in 2006.[10] UNDP's Human Development Index for the year 2006 ranks Papua New Guinea 167th out of 179 countries in the category "Combined primary, secondary, and tertiary gross enrolment ratio". The literacy rate for the adult population was estimated at 57.3 per cent in 2004, only slightly higher than in 1990. Enrolment and literacy rates continue to be significantly lower for females than for males.

Problems in Papua New Guinea's educational sector encompass a wide range of issues related to school facilities and environment, school finances, teacher and student performance, and the administration of education. Many school facilities are highly deficient, lacking for example electricity, adequate sanitation, or textbooks for students. Other problems include the remoteness of schools, frequent school closure and security issues. Parents are also discouraged to send their children to school by the lack of adequate employment opportunities. As mentioned below only a small fraction of the population in Papua New Guinea finds employment in the formal sector. While official unemployment figures are low, the IMF estimates that urban unemployment has increased to about 40 per cent, with rates being particularly high among women and youth.[11]

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[8] Under-five mortality rates are taken from the World Bank's WDI database.

[9] World Bank Country Brief, Papua New Guinea. More comprehensive information on HIV/Aids in Papua New Guinea, including detailed estimates of prevalence rates, can be found in a 2006 report "Impacts of HIV/AIDS 2005 – 2025 in Papua New Guinea, Indonesia, and East Timor" commissioned by the Australian Government.

[10] Gross enrolment data is taken from the World Bank's WDI database.

[11] IMF Article IV consultation with Papua New Guinea, March 2008.

In sum, human development remains a huge challenge for PNG. Poor infrastructure and poor maintenance, particularly in rural areas complicates the situation. Its education and health facilities are under-funded and ill-equipped, leading to less than satisfactory education and health outcomes. According to an ESCAP/ADB/UNDP[12] joint publication released in 2007, PNG is regressing or not making any progress in 8 of 17 MDG indicators for which data was available[13]. Its progress is slow in three other indicators (primary completion rate, under 5 mortality and infant mortality).

Vulnerability to economic shocks

Papua New Guinea remains highly vulnerable to natural and economic shocks due to its geographical, social, political, and economic structures. Population density is generally low and averages only one person per square kilometer in the country's Western Province. The indigenous population of Papua New Guinea is considered to be one of the most heterogeneous in the world. There are several thousand separate communities, divided by language, customs, and tradition. More than 800 languages have been identified, most of them spoken only by a few hundred to a few thousand. Moreover, most of the languages are almost entirely unrelated to each other. The mountainous terrain of the country has further contributed to the isolation of some of the communities. Land in Papua New Guinea is generally held by communities. Disputes between tribes over land ownership are frequent, and often violent.

A recent report by the Asian Development Bank indicates that the economy remains highly dualistic. It is estimated that more than 75 per cent of the labor force are engaged in subsistence farming, often under difficult conditions such as high vulnerability to pests and natural disasters. In fact, the economy is composed of an informal sector that supports the majority of the population through subsistence agriculture and a formal sector—often export oriented—which is dominated by foreign investors. Manufacturing is limited, and the service sector is small.[14]

The difficult geographical terrain, combined with the fragmentation of society, hampers economic development, for example through its adverse effect on within-country trade. The country has also been severely impacted by major economic crises and natural disasters during the 1990s (e.g. the El Nino drought, the Asian financial crisis, and a major volcanic eruption).

The share of agriculture (including forestry and fisheries) in gross domestic product has declined slightly in recent years, but remains relatively high, standing at 34 per cent in 2007. With the exception of 2006, when agricultural output stagnated, the sector has experienced robust growth since 2004 (between 2 and 4.5 per cent). Papua

[12] ESCAP/ADB/UNDP, The Millennium Development Goals: Progress in Asia and the Pacific 2007, Bangkok 2007.

[13] Base 1990: reaching grade 5, achieving gender parity in primary education, HIV prevalence, forest cover, access to safe drinking water-urban, access to safe drinking water-rural, sanitation-urban and sanitation-rural

[14] Asian Development Bank. Foundation for the Future: A Private Sector Assessment for Papua New Guinea. Mandaluyong City, Phil.: Asian Development Bank, 2008.

New Guinea's export sector is dominated by minerals, which account for 80 per cent of total exports. The share of agricultural goods in total exports was 13 per cent in 2007. The country's export earnings depend to a large extent on the price trends of its major mineral export commodities. After several years of high prices and increasing export revenues, Papua New Guinea is now likely to face an extended period of much lower prices for crude oil and copper.

Oil production in Papua New Guinea began in 1992 and reached a peak in 1993 at 126,000 barrels per day.[15] With the main production field maturing, daily output of crude oil fell to 42,000 barrels per day in 2007. The decline in net exports was even more pronounced. In 2007, the country exported an estimated 10,000 barrels per day, compared to 111,000 barrels per day in 1993. Oil revenues accounted for 22 per cent of total export earnings in 2007.

Papua New Guinea's economic vulnerability is reinforced by the lack of adequate transport infrastructure and the fact that access to electricity is very limited. Transport networks are generally poorly developed and the quality of the road system has deteriorated rapidly in recent years due to the lack of maintenance. Rural residents in some of the mountainous regions often have to walk several hours to reach the nearest road. As illustrated in several studies, the lack of access to roads has a strong effect on the various dimensions of poverty.[16] The World Bank estimates that access to electricity is only 7 per cent in rural areas of Papua New Guinea. A large part of rural schools and health facilities has no electricity.

[15] Quantitative information on oil production and export is provided by the U.S. Energy Information Administration.

[16] See for example the background paper by Diana Cammack for the Chronic Poverty Report 2008-09 entitled "Chronic Poverty in Papua New Guinea".

Zimbabwe: Country Assessment Note (February 2009)

Summary

For a decade after its independence, Zimbabwe witnessed strong economic growth and living standards improved. Since 1999, however, the country has been experiencing severe economic difficulties following balance of payments difficulties, increasing fiscal deficits, repeated droughts, and political uncertainties. The country's gross domestic product is estimated to have contracted by 40 per cent over the period 1999-2008. Unemployment is rampant and hyperinflation has devastated purchasing power of households. The country is facing severe difficulties in maintaining a minimum infrastructure for the delivery of basic services, such as clean water and sanitation and power supply, with negative implications for health and education outcomes.

Zimbabwe has been facing deterioration in its social indicators and the recent outbreak of cholera compounds an already tenuous situation. In November 2008, former United Nations Secretary-General Kofi Annan declared: "What we have learned in the past few days is shocking. It is not just the extent of Zimbabwe's humanitarian crisis, but the speed of deterioration in the past few weeks that is most worrying. The scale, depth and urgency of the situation are underreported".[1]

Background

In 2007, the CDP decided that if a country is preliminarily found eligible for inclusion in the LDC list by the expert group preparing for the triennial review, DESA would prepare a country assessment note for the plenary session of the Committee. The assessment note should corroborate the basis for the finding of eligibility from statistical evidence and incorporate other relevant information. Particular consideration should be given to the reasons for recent deterioration of economic and social conditions in the country in order to determine whether the deterioration is due to structural or transitory factors. Assessment notes will be transmitted to the country (prior to the plenary meeting), which will have the opportunity to produce a written statement for the plenary meeting, including the possibility of expressing its objection in principle to being added to the list of least developed countries.

According to the preliminary triennial review of the list of the Least Developed Countries undertaken by the expert group meeting of the Committee for Development Policy on 27-29 January 2009, Zimbabwe satisfied the three the criteria for inclusion (income, human

[1] The Zimbabwean, 25 November 2008. Available at: http://www.thezimbabwean.co.uk/index.php?option=com_content&task=view&id=16615&Itemid=116

asset index (HAI) and economic vulnerability index (EVI)) in the LDC category. Zimbabwe was also found eligible for inclusion at the 2006 triennial review (see table 1 below) but had opted not to join the category. In the country's view, GNI had declined due to temporary economic setback caused by sanctions imposed by some Western countries and successive years of drought since 2000.[2]

Table 1
Zimbabwe: 2006 and 2009 triennial review of the list of LDCs

Criteria	GNI per capita (US$)	Human Asset Index (HAI)	Economic Vulnerability Index (EVI)
2006 Triennial review			
Inclusion threshold	< 745	< 58	> 42
Country's values	463	53	48
2009 Triennial Review (preliminary results)			
Inclusion threshold	< 905	< 60	> 42
Country's values	340	56	64

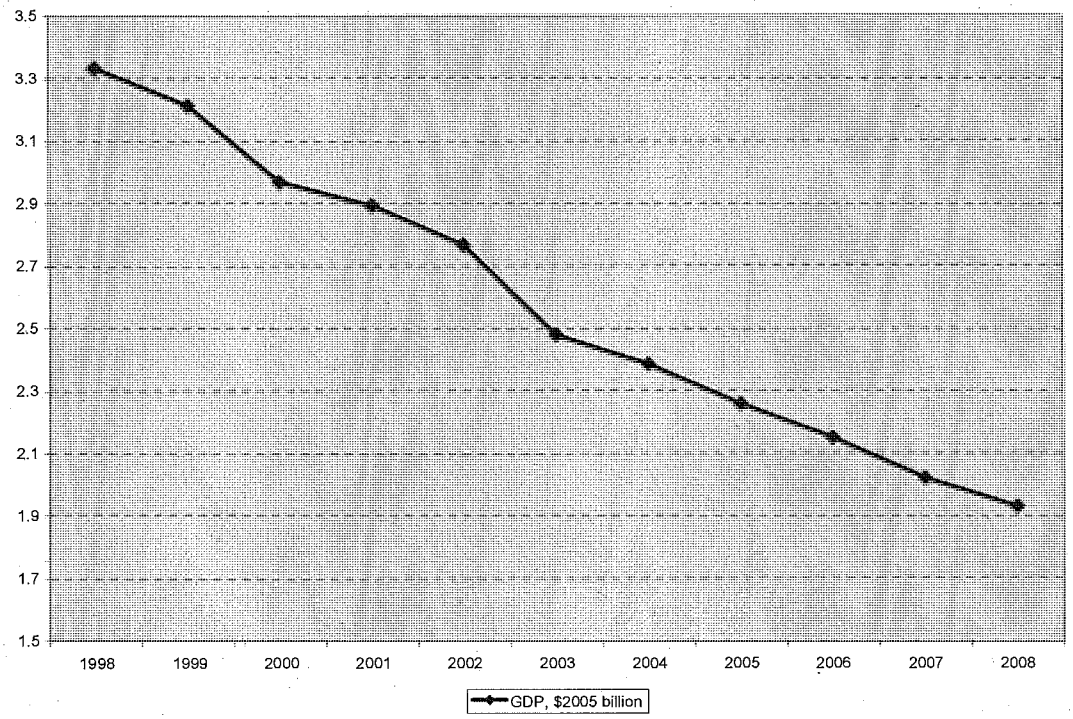
Source: Committee for Development Policy report on the eighth session (20-24 march 2006) Economic and Social Council Official records, 2006, Supplement 13 (E/2006/33) and UN DESA.

Recent economic performance

Adverse weather conditions, expansionary fiscal and monetary policies coupled with difficulties resulting from the implementation of land reform and limited external financing have contributed to a persistent decline of the economy over the past decade (see figure 1). Shortages of foreign currency as well as fuel, food and other essential consumer goods are acute. With limited access to external sources of finance, the public deficit has been financed by a massive expansion of money supply leading to an annual inflation rate of 231,000,000 per cent in July 2008.[3]

[2] Letter from the Secretary of Foreign Affairs of the Republic of Zimbabwe, Mr. J. M. Bimha, to the Secretary of the Committee for Development Policy, dated 30 March 2006.
[3] Reserve Bank of Zimbabwe, 2008, Inflation Statistics. http://www.rbz.co.zw/about/inflation.asp

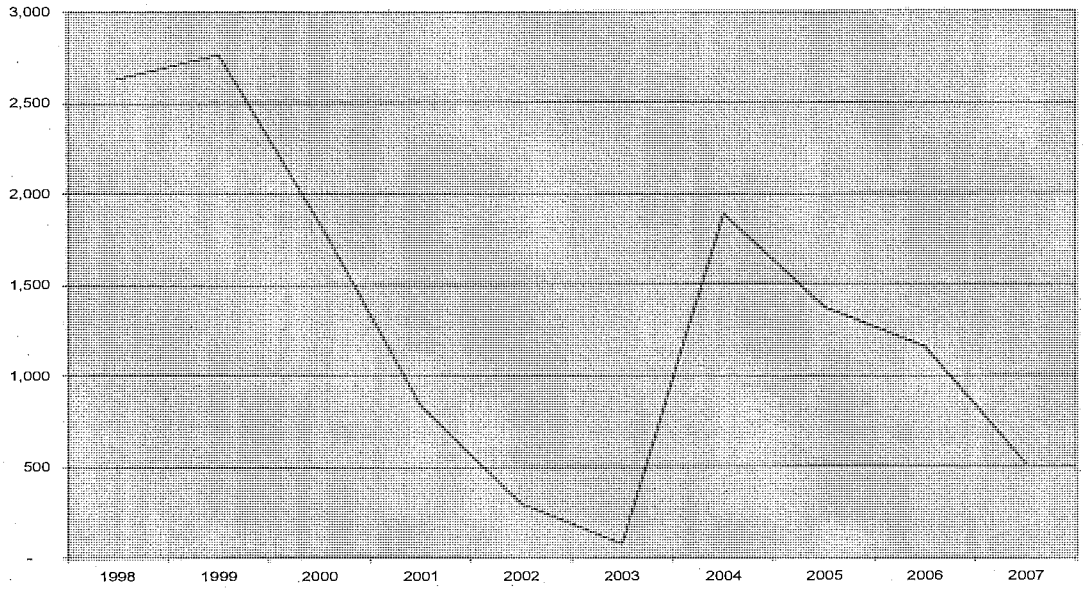
Figure 1. Zimbabwe: Gross domestic product, 1998- 2008 (US$ 2005 billion)



Source: UN DESA/World Economic Situation Prospects database

Endowed with fertile lands, Zimbabwe used to have a diversified and productive farming sector. Difficulties in the implementation of the "Fast-Track Land Reform Program" since 2000 – which sought to address the land distribution pattern inherited at independence in 1980—and repeated droughts have resulted in lower agricultural output with negative consequences for exports. According to FAO estimates, agricultural output declined by some 30 per cent over the period 2001-2005. Exports (particularly tobacco and horticultural crops) witnessed sharp volatility and a declining trend over the period 1998-2007 (see figure 2) despite the strengthening of commodities prices observed during the period. Greater volatility of agricultural output (as well as of export earnings) contributed to a sharp deterioration of the country's EVI relative to the inclusion threshold (see table 1 above). Additionally, distorted input and output markets, weak agricultural support services, as well as acute shortages of essential inputs (seeds, fertilizer and fuel), have affected local food production and led to increased reliance on food imports and food aid to supplement local production.

Figure 2. Zimbabwe: exports of goods and services, 1998 – 2007 (US$ million, current)



Source of data: UN Statistic Division National Account online database

According to FAO, the current food security situation in Zimbabwe is severe. Flooding followed by extreme dry weather caused considerable damage to the 2008 maize harvest at a time when international maize prices were at a premium. A large part of the country experienced a 75 to 100 percent crop production deficit last year. As a result, the food security of a large part of the population continues to deteriorate. A recent FAO report estimated the number of food insecure at 5.1 million which represents approximately 40 per cent of the population.[4]

Zimbabwe used to have one of the most diversified and integrated manufacturing sectors in sub-Saharan Africa. The sector has been affected by the general deterioration of the macroeconomic environment in the country, including the lack of competitiveness caused by the overvalued exchange rate, the shortage of foreign exchange for purchasing inputs and, more recently, price controls adopted to control rampant inflation. Lower agricultural output also impacted negatively on manufacturing activities. Moreover, frequent power blackouts continue to plague both commercial and residential users.

Zimbabwe is endowed with mineral resources and has great potential for tourism. However, as the upward trends in global commodity prices reversed sharply since mid-2008 and prices are expected to continue to decline along with the moderation in global demand, the already low revenues of Zimbabwean merchandise exports are expected to

[4] Food and Agriculture Organization of the United Nations, 2008, Crop Prospects and Food Situation, No.4, October 2008, Food and Agriculture Organization of the United Nations.

continue to decrease in the future. Tourism revenues will continue to be affected by the political and humanitarian challenges confronting the country.

A shortage in foreign exchange has made it increasingly difficult for the country to service its external debt and has led to the accumulation of arrears to its main creditors. Zimbabwe's external debt reached $5.2 billion in 2007 (compared to an estimated GDP of $2.1 billion), while accumulated arrears on interest payments totaled $720 million.[5] Zimbabwe is currently ineligible to receive fresh loans from the International Monetary Fund (IMF) and the World Bank's International Development Association (IDA). While the country cleared its arrears to the IMF GRA Account in February 2006, it remains in arrears towards the Poverty Reduction and Growth Facility-Exogenous Shocks Facility (PRGF-ESF) Trust. Zimbabwe also advanced towards clearing arrears with the African Development Bank in 2008.

Due to growing concern over political developments in the country, some governments have imposed targeted measures such as the restriction on travel and asset ownership for selected senior government officials and a weapons trade embargo. Bilateral assistance is largely centered on humanitarian aid and mostly limited to food aid and to health issues such as HIV/AIDS. According to OECD, net disbursements by DAC donors reached $465 million in 2007 and averaged some $300 million per year over the period 2003-2007.

Structural handicaps to growth and development

A landlocked country, Zimbabwe used to have well-developed road and railway networks, thus facilitating the country's access to transit countries and importing markets. Unfortunately, its physical infrastructure has deteriorated in the absence of funds or skills to undertake regular maintenance, modernization and expansion. The 2006 World Bank "Zimbabwe Infrastructure Assessment Note" concluded that about 40 percent of the road network is in "poor" condition. Similarly, according to data from the Reserve Bank of Zimbabwe, the railway freight traffic declined from 12 million tons in 1999 to 3.9 million tons in 2005.

Population growth in Zimbabwe has been relatively low, largely due to migration and increased mortality due to the AIDS pandemic. A UNDP report indicated large-scale emigration (according to some estimates of at least 2 million Zimbabweans are thought to be living outside the country[6]) including a considerable exodus of professionals. This brain drain has severe consequences on the ability of the country to maintain and improve upon productivity, to deliver necessary social services and constrains the country's capacity to recover from the on-going economic and social difficulties. At the same time

[5] External debt data comes from the World Bank's Global Development Finance online database while GDP estimates are from UN Statistics Division National account online database.

[6] UNDP Zimbabwe, "Comprehensive Economic Recovery in Zimbabwe, A Discussion Document", available at http://www.undp.dk/assets/Andre-rapporter/UNDP-Comprehensive-Economic-Recovery-in-Zimbabwe.pdf

remittances, in the form of goods and money, from relatives and friends working abroad have been a lifeline for many Zimbabwean households.

As a reflection of the economic deterioration and growing unemployment, poverty increased in the country. The United Nations Office for the Co-ordination of Humanitarian Affairs has stated that, "at the end of 2008, only 6 per cent of the population was formally employed, down from 30 per cent in 2003."[7] The proportion of households below the Total Consumption Poverty Line increased from 25 percent in 1990 to 42 per cent in 1995 and reached 63 percent in 2003.[8] Inequality-- as measured by the Gini coefficient-- rose from 0.57 to 0.64 in the period 1995-2003.

Most of Zimbabwe's social indicators, which were among the best in sub-Saharan Africa, have deteriorated since their peak in the late 1980s, and there are concerns whether the country may be able to meet the Millennium Development Goals (see table 2 below):

Table 2
Zimbabwe: selected health indicators

Maternal mortality ratio (per 100 000 live births)		Infant mortality rate (per thousand live births)		Tuberculosis prevalence rate (per 100,000)	
	Ratio		Per cent		Indicator
1990	570	1990	52	1990	248
1995	610	2003	78	2000	412
2000	1100	2004	78	2004	673

Source: WHO, Country Health Fact Sheet, 2006 and World Bank, World Development Indicators online database.

By the end of 2008, the health and education systems were reported to be completely paralyzed. As the health situation worsened over the last two decades, life expectancy at birth declined from 62 years in 1990 to 43 years in 2007. Most health facilities have closed down or provide sub-standard services due to the lack of skilled staff, medical supplies and equipment.[9] There is, however, some encouraging news. The latest data regarding the prevalence of HIV/AIDS show a reduction of infected people. The prevalence rate was estimated at 15.3 percent in 2007, giving Zimbabwe the fifth highest rate in the world. World Bank noted that "Water and sanitation coverage is about 30 percent below requirement, due to problems of co-ordination, an outdated policy environment, unsustainable tariff regimes, and limited administrative capacity. Access

[7] UN OCHA, Zimbabwe Consolidated Appeal (CAP 2009). http://ochaonline.un.org/zimbabwe/AppealsFunding/CAP2009/tabid/5120/language/en-US/Default.aspx

[8] Ministry of Public Service Labour and Social Welfare 2006, 2003 Poverty Assessment Study Survey: Draft Main Report.

[9] UNICEF Zimbabwe, 2008, Immediate Needs of Children and Women Affected by the Cholera Outbreak and Collapse of the Health and Education Systems, December 16th 2008. Available at: http://www.unicef.org/infobycountry/files/Zimbabwe_Immediate_Needs_16_Dec_2008_CORRIGENDUM.pdf

continues to decline; for instance, rural water coverage declined from 75 to 70 percent in the five years to 2004. About US$10 billion is needed to rehabilitate the system."[10]

The recent cholera epidemic indicates further deterioration of the country's health situation. Between August 2008 and 30 January 2009, at least 3,100 people died, more than 60 thousand people were infected, while the outbreak was far from being brought under control according to the WHO.[11] The Government is concerned that the situation will get worse as the rainfall intensifies and floods occur during the rainy season which peaks in January or February and ends in late March.

Human capacity in general has been eroded due to the impact of HIV/AIDS and migration. Zimbabwe's educational system, which used to be described as a "jewel in Africa", has also suffered over the last decade and is now facing a serious crisis. From 1999 to 2003 (latest available year), the completion rate of primary education decreased from 90 to 81 per cent[12]. Recent news shows that the downward trend is likely to have continued. At the beginning of 2009, Zimbabwe postponed the opening of schools by two weeks due to the country's worsening humanitarian crisis. The deterioration of the education system may impact further on HAI in the future as the country's relatively high adult literacy rate may not be maintained and school enrolment decline.

[10] World Bank Interim Strategy Note, FY08-09 for the Republic of Zimbabwe, April 12, 2007, Report No. 39128-ZW., p. 8.
[11] WHO, Global, national efforts must be urgently intensified to control Zimbabwe cholera outbreak (news release, 30 January 2009)
[12] World Development Indicator, Online database, World Bank.

UNOFFICIAL TRANSLATION

Written statement by the delegation of Equatorial Guinea before the plenary session of the Committee for Development Policy on the Least Developed Countries
New York, March 2009

Equatorial Guinea has a land surface of 28,051.46 km^2 and 1,014,999 inhabitants (2001 population census). The population is very young (47.3 per cent of which is aged 14 and under), has a high birth rate (43.2 per cent), has life expectancy at 59.3 years, grows at 2.8 per cent per year and is largely rural (61.2 per cent).

According to the United Nations Development Programme, Equatorial Guinea's Human Development Index (HDI) deteriorated over the last years as the country's rank, in relation to group of 177 countries, dropped from 121st in 2005 to 127th in 2008.

Thanks to the discovery of hydrocarbons (95 per cent of the gross domestic product), Equatorial Guinea experienced high rates of economic growth over the last ten years and a fast development of much needed infrastructure (roads, ports, airports, housing, schools, water and sanitation, power supply, etc).

Despite rapid economic growth, however, the economy remains extremely fragile due to its excessive dependence on the oil sector. This fragility in underlined by the following factors:

1. Oil is a non renewable resource;

2. Oil prices are volatile in international markets. Currently, the country is facing fiscal difficulties as oil prices declined. In fact, for the current year (2009) oil revenues, which account for 95 per cent of fiscal revenues anticipated for the year 2009, are 65 per cent lower than forecast as oil prices fell from $100 per barrel (prudential estimate used for the purposes of budget preparation) in the third quarter of 2008 to the current level of $35 per barrel;

3. Oil production displaced all traditional productive sectors of the economy. Exports of timber and cacao, the main source of growth of the economy in the past, have almost disappeared as a share of total exports. Currently, timber exports account for about 1 per cent of total exports, dropping from 40 per cent in 1990. This highlights the dependence of the economy on one single product and, therefore, its fragility.

4. At the same time, some 90 per cent of all basic goods consumed in the country are imported. This situation, together with the petroleum euphoria and inflation, is unbearable for the population and is leading to the emergence of endemic poverty as well as the concentration of economic activity in the main cities.

In view of the above, the Government of Equatorial Guinea organized two national conferences on the economy: one in 1997, after the discovery of oil, the other in 2007.

On the basis of the conclusions and recommendations of these conferences, the Government the National Development Strategy to 2020 whose main pillars are:

1. Create an enabling environment for investment (private and public) so that in 2020 Equatorial Guinea can be truly considered an emerging country with a solid and diversified economy;

2. Create the base for diversifying the productive structure of the economy thus avoiding the present trend of absolute dependence on oil.

On the basis of the above premises and taking into account that the Strategy cannot be implemented overnight, Equatorial Guinea as a member of the least developed countries requests the support of the international community to carry out this ambitious plan by remaining in the group of LDCs, which is justified by the following:

a) the criteria for classifying countries as LDCs are not exclusively based on per capita GDP but take into account other relevant factors such as the level of human resource development, life expectancy, per capita caloric intake, food safety, literacy rate, the diversification of the economy and the vulnerability index, UNCTAD's index of export concentration, the manufacturing industry and the share of labour in manufacturing, the annual consumption of energy, etc.

In view of this panorama, Equatorial Guinea asks for a period of transition up to the year 2020—the year when the implementation of current Development Strategy will be finalized—before it can be reclassified. During this period of transition, it requests a technical cooperation monitoring and follow-up programme to the United Nations which should take into account the following aspects:

- Assistance to conduct a population census for the year 2010 as the present inconsistency of demographic data is an issue of contention for coherent planning;

- Assistance to establish a national statistics programme to harmonize data in a single, common database;

- Assistance to develop human resources in key areas;

- Assistance to develop and Action Plan for the diversification of the economy, as well as any other aspect that United Nations find relevant to support us in this process.

These requests by the Government of Equatorial Guinea rely on the following instruments:

a. General Assembly resolution 59/209 on a smooth strategy for countries graduating from the list of least developed countries;

b. Committee for Development Policy: Report on the ninth session (19-23 March 2007). Official Records of the Economic and Social Council 2007, Supplement 33, chapter IV, Procedures for inclusion of countries in and graduation from the list of least developed countries and the interactions with the countries concerned;

c. Third United Nations Conference on the Least Developed Countries held in Brussels (Belgium) from 14 to 20 May 2001, and which adopted the Programme of Action for the Least Developed Countries for the Decade 2001-2010.

Malabo, February 2009

República de Guinea Ecuatorial

EXPOSICION DE MOTIVOS DE LA DELEGACION DE GUINEA ECUATORIAL ANTE EL COMITÉ PARA LA POLITICA DE DESARROLLO

NACIONES UNIDAS

NUEVA YORK, 23 DE FEBRERO 2009

EXPOSICION DE MOTIVOS DE LA DELEGACION DE GUINEA ECUATORIAL EN LA REUNION PLENARIA DE

LOS PAISES MENOS ADELANTADOS (PMA)

EN NUEVA YORK EN MARZO DE 2009

Guinea Ecuatorial es un país de 28 051,46 km^2 de superficie, con una población de 1 014 999 (censo de población 2001), con una población muy joven (47,3% de 0 a 14 años) y alta tasa de natalidad (43,2%), tiene un crecimiento demográfico de 2,8%, la esperanza de vida al nacer es de 59,3 años y la mayor parte de la población es rural (61,2%).

El Índice de Desarrollo Humano (IDH) del PNUD para Guinea Ecuatorial ha empeorado los últimos años, pasando del puesto 121 en 2005 a 127 en 2008, sobre una lista de 177 países

Gracias al descubrimiento del petróleo (95% del PIB), la República de Guinea Ecuatorial registra desde hace más de una década un crecimiento económico elevado, que se traduce principalmente en un desarrollo acelerado de las infraestructuras, sectores vitales de los que el País adolecía (carreteras, puertos, aeropuertos, viviendas sociales, infraestructuras escolares, abastecimiento de agua a las ciudades, electricidad, etc.).

Sin embargo, a pesar de este crecimiento económico, la economía de Guinea Ecuatorial es extremadamente un "**frágil**", debido a la excesiva dependencia hacia el sector petrolero. Esta fragilidad se justifica por los siguientes aspectos.

1 El petróleo es un producto perecedero no renovable,

2 La fluctuación internacional del precio del barril de crudo En la actualidad, el país conoce dificultades presupuestarias debido a la generación de recursos cada vez menor En efecto, para el presente ejercicio económico 2009, los ingresos petrolíferos, que representan el 95% del total de los ingresos presupuestados para el 2009, están sufriendo una reducción de 65% debido a la bajada del precio del barril, que ha pasado de 100 dólares (como base prudencial de cálculo) en el tercer trimestre de 2008 al precio actual de 35 dólares.

3 El desarrollo de la producción petrolífera relegó al segundo plano todos los sectores tradicionales de la economía La madera y el cacao, principales fuentes de la economía en los años 1990, han desaparecido casi de las exportaciones Así pues, la madera que representaba un 40% de las exportaciones en 1990 sólo representa en la actualidad un 1% Esta situación

significa la dependencia de un solo producto y por consiguiente fragilidad en la Economía

4 Por otro lado, el 90% de los productos básicos que se consumen en Guinea Ecuatorial es importado, esta situación unida a la euforia petrolera, la inflación que afecta a nuestros mercados es inaguantable por la población y está propiciando el desarrollo de una pobreza endémica y la concentración de la actividad económica en las principales ciudades

En vista de todos estos datos, el Gobierno de Guinea Ecuatorial ha tratado de paliar estas limitaciones organizando dos conferencias económicas nacionales, una en 1997, con la aparición del petróleo y la otra en 2007.

Con las conclusiones y recomendaciones de dichas conferencias, el Gobierno ha elaborado la Estrategia de Desarrollo Nacional al Horizonte 2020, cuyos principales ejes son:

1. Crear un ambiente propicio para la inversión (pública y privada), para que al horizonte 2020, Guinea Ecuatorial sea considerado verdaderamente como país emergente, con una economía sólida y diversificada;

2 Crear las bases para diversificar las fuentes productivas de la economía, evitando la tendencia actual de dependencia absoluta del petróleo,

Con estas premisas y teniendo en cuenta que este Plan no se puede ejecutar de la noche a la mañana, Guinea Ecuatorial, como miembro de los Países Menos Adelantado (PMA), ha recurrido a la comunidad internacional para solicitar su apoyo para la implementación de este ambicioso Plan, que comienza con la permanencia de Guinea Ecuatorial en el Grupo de los Países PMA, justificado por:

- a) Los criterios de clasificación no se basan únicamente en el PIB per cápita, sino que tienen en cuenta otros factores muy importantes como la debilidad de los recursos humanos, la esperanza de vida al nacer, el consumo de calorías per cápita, la seguridad alimentaria, la alfabetización, el nivel de diversificación de la economía y el índice de vulnerabilidad, el índice de concentración de exportación de mercancías de la UNCTAD, la industria manufacturera nacional y la proporción de la población activa en la industria, el consumo anual de energía, etc

Ante este panorama, la República de Guinea Ecuatorial solicita un periodo de transición hasta el año 2020, año en que se concluye la Estrategia de Desarrollo actual, para ser reclasificado. Durante este periodo de transición solicita a las Naciones Unidas un Programa de Acompañamiento en asistencia técnica basado en los siguientes aspectos concretos:

- Asistencia para elaborar un censo nacional de población para el año 2010, pues la inconsistencia actual de datos demográficos constituye un punto de conflicto para la planificación coherente;
- Asistencia para formular un programa estadístico nacional, con el fin de armonizar los datos con una base de datos única;
- Asistencia para la formación del personal en áreas claves de desarrollo,
- Asistencia para la elaboración el Plan de Acción para la diversificación económica y cualquier otro aspecto que las Naciones Unidas pueda identificar como crucial para apoyarnos en este proceso.

Estas solicitudes del Gobierno de Guinea Ecuatorial se sustentan en los siguientes instrumentos:

a Resolución de la Asamblea General de las Naciones Unidas nº 59/209, sobre la Estrategia de transición gradual de los países que queden excluidos de la lista de los Países Menos Adelantados;

b Comité de Políticas de Desarrollo. Informe sobre el noveno período de sesiones (19 a 23 de marzo de 2007), del Consejo Económico y Social (Documentos Oficiales, 2007, Suplemento No. 33), sobre Procedimientos para la inclusión de países en la lista de países menos adelantados y su exclusión de la misma y para la interacción con los países en cuestión;

c Tercera Conferencia de las Naciones Unidas sobre Los Países Menos Adelantados, celebrada en Bruselas (Bélgica), 14 a 20 de mayo de 2001, donde se elaboró el Programa de Acción en Favor de los Países Menos Adelantados para el decenio 2001-2010

Malabo, Febrero 2009

Graduation of Tuvalu from the Least Developed Country category
Department of Economic and Social Affairs
Secretariat for the Committee for Development Policy
9 March 2009

TUVALU: ECONOMIC OVERVIEW AND MAJOR CHALLENGES

BACKGROUND

1. The Tuvalu Government submitted to the UN Committee for Development Policy (hereafter the "Committee") substantial documentation that supports the Government's contention that Tuvalu should not graduate from LDC status. This note summarizes the major arguments why Tuvalu should maintain its LDC status. It re-emphasizes the fragility and vulnerability of Tuvalu's economy, and outlines the key challenges that Tuvalu presently confronts to maintain economic and social progress.

2. The Committee found that Tuvalu met two of three UN criteria for graduation off the LDC list. These are: gross national income (GNI) per capita, and the human asset index (HAI: nutrition, child health, school enrolment, adult literacy).

3. In contrast:

- Of the 68 countries surveyed at the 2006 CDP Triennial Review, Tuvalu had the worst economic vulnerability index (EVI): external shocks, structural exposure to shocks, structural handicaps.
- Tuvalu has the highest exposure index and shock index.
- Tuvalu has the highest agricultural instability index, and second highest export instability index.[1]
- Tuvalu's EVI (79.7/100) is 41 points above the graduation threshold of 38.
- Tuvalu ranks as the most economically vulnerable country in the world.

4. Under the above criteria, Tuvalu received graduation marks in two of three criteria, but this methodology severely under-weighted the importance of EVI in Tuvalu's uniquely fragile development and economic context. Giving equal weight to such broad indicators will naturally under estimate Tuvalu's severe economic (and environmental) vulnerability.

5. Past economic progress in Tuvalu, by any number of measurements, has been respectable for a resource poor nation of 10,000 people. Tuvalu's long-held emphasis on investment in education and training is reflected in the good results seen in the HAI. The growth of its GNI per capita has grown steadily, but it is built on a fragile base that relies on the health of global financial markets, continuous (and sizeable) flows of development aid, and prudent fiscal management.

6. Although Tuvalu's relatively high GNI and HAI suggest LDC graduation, the progress these criteria measure could easily, rapidly unravel due to Tuvalu's inherent economic vulnerability.

7. We counter that Tuvalu should not graduate from LDC status, unless Tuvalu also meets the EVI graduation criteria. Despite high GNI and HAI measures, Tuvalu has such weak EVI measures that graduation from LDC status at this stage of Tuvalu's development is premature, unnecessarily exposes Tuvalu to greater risk, and increases the country's economic vulnerability – not lessen it.

ECONOMIC OVERVIEW

8. At independence in 1978 Tuvalu faced a bleak economic future. There were widespread fears that Tuvalu was not a viable nation. Since then support for Tuvalu from aid donors has been steady and substantial. This support has played a central role in Tuvalu's development, as measured across a range of economic and social indicators. Loss of LDC status will eventually undercut aid assistance, which will jeopardize the economy, and put a drag on future development.

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[1] Tuvalu's export vulnerability index is further exaggerated because Tuvalu is a non-trading nation in merchandise exports, and has a structural/inherent inability to develop a manufacturing sector in which to produce merchandise exports that earn foreign exchange. This is yet another example of Tuvalu's economic vulnerability and the fragile nature of its economy.

9. Often repeated are Tuvalu's many well-known economic constraints:

- Isolation, especially from major markets;
- Limited natural resources (with the possible exception of marine resources);
- A small, geographically dispersed population; and
- Limited access to human and financial capital, to name but a few.

10. It is arguable that Tuvalu is the world's most remote country, as measured by access to it, distance, transport costs, and other factors. Tuvalu is among the smallest countries by land area and population.

11. Apparent progress under the GNI and HAI criteria are only broad interpretations of Tuvalu's economic and social progress. Economic performance remains fragile and challenged by many external factors that are well beyond domestic influence or control. GNI per capita can be a misleading indicator of economic health. Tuvalu has a high cost of living, and is heavily dependent on imported food and wholly dependent on imported fuel. Its GNI per capita at purchasing power parity (PPP) is among the lowest in the world. Of 192 countries recently surveyed, Tuvalu ranks 18th from the bottom (176), below all other SIDS and only a few other LDCs.[2]

12. In spite of these constraints Tuvalu has a record of economic progress, though its vulnerability has made Tuvalu's progress fragile and at continuous risk of reversal. Tuvalu has a well-deserved, and hard-earned reputation for getting favorable returns from its meager resource base – natural, financial and human. Tuvalu, however, is and remains extremely exposed to global economic forces that are entirely outside the country's control.

13. Rarely has Tuvalu been more vulnerable than it was in 2008. Over the past year the economy reeled under sharp spikes in the cost of imported food and fuel. This put severe strain on the Government and the nation. Below is but one comparative example:

- In mid-2008, gasoline prices in the U.S. were around US$4/gal.
- In Tuvalu, gas prices reached $12/gal, or three times the price of fuel paid for in the U.S., a country many orders of magnitude richer.

14. In Tuvalu, spending cuts ensued, national (and unaffordable) subsidies increased, and household budgets got squeezed, badly. While prices for food and fuel have eased somewhat, they still remain at historic highs due to unfavorable exchange rates, import time lags, and high transport costs.

15. Presently, Tuvalu's economy has been hard hit by the flow-on effects of the global financial crisis. Beginning in 2008, the portfolio value of the Tuvalu Trust Fund (TTF) started to collapse. Obviously, it won't recover anytime soon. The TTF is the foundation of much of Tuvalu's macroeconomic stability and financial sustainability, with zero income expected from the TTF for years to come.

17. Other foreign-sourced income also feeds the Tuvalu economy, mostly through the national budget. So far these income sources remain relatively strong, in part because many of them are denominated in US$. The recent, large depreciation of the Australian dollar (A$) means that US$-based assets and the income derived from those assets may increase in 2009. This may sound good, but it is not. It only reinforces the vulnerability of Tuvalu's economy, highlighting those economic factors that are outside Tuvalu's control, which may just as easily move against the Government – and fast.

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[2] *Sources:* IMF - International Monetary Fund, World Economic Outlook Database, April 2005;CIA: The World Factbook (2005, covers countries not mentioned by the IMF, information may refer to 2004 or earlier.) Slightly different figures will be found at Country Economies Classification of The World Bank Group. See: http://www.nationsonline.org/oneworld/GNI_PPP_of_countries.htm.

18. In mid-2008, when Tuvalu faced historically high food and fuel prices, the A$ was almost at parity with the US$. Projections were income from the TTF would drop to zero. They did and are not expected to recover for at least several years. The Government confronted a fiscal crisis.

19. Given the situation the Government maintained fiscal discipline, moved to reduce its debt obligations, and moved to build its cash reserves. Nonetheless, the Government was still unable to balance its 2009 Budget. As a precautionary measure, the Government sought and received one-off grants from Australia and New Zealand to boost its cash reserves that should help Tuvalu navigate through the current global financial crisis and the ancillary impacts that it will impose on Tuvalu.

MAJOR CHALLENGES

20. At any time, Tuvalu confronts many challenges to develop its economy. The challenges we now face are more difficult than ever before, and could prove insurmountable if Tuvalu loses its LDC status.

21. In Tuvalu, the public sector dominates the economy. Which means prudent macroeconomic policy is vital to achieve medium-to-long-term economic progress. The foundation of Government macroeconomic policy is a fiscal strategy anchored by the Tuvalu Trust Fund, and annual income earned from the TTF. The TTF has a balanced portfolio, invested around the world in a mix of equities and fixed-interest securities. In good years, decision-makers use real TTF returns to fund the national budget's structural deficit. In bad years, such as now and for the foreseeable future, Tuvalu's inherent economic and financial vulnerability is exposed.

22. Tuvalu has taken steps to reduce the volatility inherent in TTF investments by building a buffer account that grows in good times and can be drawn down when TTF returns are poor or non-existent. But the current global financial crisis could threaten the basis of this policy. If the crisis is protracted, currently the worst seen in 80 years, many of the assumptions upon which the TTF was established will be sorely tested if Tuvalu's cash reserves run out.

23. Another challenge facing Tuvalu is to maintain its other major sources of income: fishing licensing; income from the marketing and licensing of .tv, Tuvalu's country-code internet domain name; foreign aid; and remittances. Each of these sources are dependent upon factors outside the control of Government.

24. Income from fishing licenses, .tv, and foreign aid all flow through the national budget, and are subject to annual spending and distribution priorities. All could be severely affected by the current crisis. The Government's most worrisome scenario is one where all these revenue sources fall at the same time – a real possibility in such uncertain times.

25. Amplifying the current crisis could be a fall in remittance income from workers overseas, most importantly seafarers employed on foreign merchant ships. Though this source of economic support has remained relatively stable over the years accurate figures have been difficult to quantify since remittances are a private income flow. If world trade contracts by double digits, the number of seafarers employed will fall, which would have a sudden and severe impact on household income.

26. Tuvalu's greatest potential challenge, among many: If all these sources of income decline at once, domestic revenue would dry up, GNI would start contracting, and HAI indicators would decline over time. The loss of LDC status at such a critical juncture would severely restrict Tuvalu's ability to sustain current level of development.

Republic of Vanuatu

A Special Submission to the UN Committee for Development Policy on Vanuatu's LDC Status

A special request to the CDP to reconsider excluding Vanuatu from 2009 triennial review due to the high vulnerability of the economy to the current global economic crises and the unreliability of statistical information

Table of Content

1. Introduction

Vanuatu was accorded an LDC status in 1995 and later in 1997, it was found pre-eligible for graduation when it's GNP per capita and HAI thresholds were met, but was put on hold in 2000 after a downturn in the HAI score. In 2006, a triennial review of the status of least developed countries undertaken by the Committee for Development Policy (CDP) had concluded that Vanuatu is one of the countries eligible for graduation because it has performed above the threshold for graduation on GNI per capita and HAI criteria which then stood at US$ 1,187 and 66 respectively for the first time since 1997. The next triennial review will be held in June, 2009 and if Vanuatu continues to perform well in two or all of the three criteria, its qualification for graduation will be finally endorsed and in 2013, Vanuatu would lose its LDC treatment.

This report is being prepared purposely to ask the CDP to consider excluding Vanuatu from the current list of LDC countries recommended for graduation from their LDC status due to two major arguments. Firstly, the Vanuatu Government maintains its stance that the timing for Vanuatu's graduation from its current LDC status is quite too early simply because Vanuatu's income base is comparatively weak due to its limited resources it owns, thus making it difficult to sustain high growth performances in the long run. Additionally, due to its highly vulnerable and fragile economic status, market shocks such as the current global economic crises is likely to have significant effects on its national output. Thus, the Government feels that it would be more appropriate that Vanuatu be exempted from this year's triennial review until the full impacts of the current global economic crises have been assessed.

Secondly, the Government is still not comfortable with the data used to calculate Vanuatu's performance against the three criteria, more specifically the Human Asset Index. Interestingly, some of the data used are found to be inconsistent with the national statistics data available in the country. Thus, the Government feels that it would not be fair for Vanuatu to be recommended for accession from LDC status based on some inconsistent information. The Government through the National Statistics Office will be addressing the data gaps and discrepancies through its current four year strategic plan and work program. For this reason, the Government also requests that Vanuatu be exempted from this year's triennial review of LDC countries, until 2012 when the relevant statistics should have been identified and nationally approved by the Government.

Finally, the paper places more emphasizes on the current highly vulnerable status of the economy which is the major argument why the Government feels it is quite premature for the Country to graduate from its LDC status. Along this line, the Vanuatu Government is planning to make a submission to the UN General Assembly for a change in the LDC graduation rule, later in the year.

2. Update on Vanuatu's LDC Status

2.1. GNP per Capita

The GNP per capita criteria requires a threshold of USD 745 in order for a country to be listed as an LDC. In order for a country to be eligible for graduation, it has to achieve at least USD 900 over three consecutive years and this was the case for Vanuatu during the 2006 triennial review when it was found to have performed exceptionally well that the average GNP per capita for years 2002-2004 was USD 1,187.

Economic growth during the last three years has been performing remarkably well with real growth rates of 6.5, 7.4 and 6.8 percent for years 2005, 2006 and 2007 respectively. The average GNP for these three years is around USD 439 million and by using a medium population estimate of 224,971 for 2007 would give a GNP per capita figure of USD 1,951.36 compared to the UN's USD 900 threshold for graduation.

2.2 Human Asset Index (HAI)

The criteria used for the HAI composed of four indicators, two for health and nutrition which are mortality rate for children aged five years or under, and percentage of population undernourished and the other two for education, gross secondary school enrolment ratio and the adult literacy rate.

2.2.1 Under Five Mortality Rate

The 1999 National Population Census reports that under 5 mortality rate has declined substantially since the first official census taken in 1967. The figure has reduced from 58 per 1,000 live births in 1989 to 33 in 1999. However, a recent UNICEF data shows a figure of 40 per 1,000 in 2004 compared to 62 in 1990, but, a more recent CDP estimate in 2006 indicated a slight deterioration to 42 per 1,000. Data discrepancy is a big issue in Vanuatu and therefore it is very important that this problem is addressed before a formal decision on Vanuatu's LDC status is made based on some reliable statistics.

Although around eighty percent of the population has access to basic health services, this varies from 100% in the urban to only 75% in the rural areas. The quality of health services available to many in the rural areas is still poor and physical access has proven to be still difficult.

2.2.2 Percentage of Population Undernourished

Currently, there are national statistics available on the proportion of population which is undernourished in Vanuatu. However, given the large income disparity which exists in the country especially in the urban areas resulting in pockets of undernourishment as highlighted by an urban squatter settlement report in 2002 which identified the following difficulties as very common;

- Lack of services: water supply, electricity for lighting, rubbish collection, public transport;
- Poor living conditions: poor housing and unhealthy surroundings, particularly from poor drainage; and
- Difficulty in meeting their basic needs for food, clothing and money because of insufficient incomes or jobs.

Temporary undernourishment is also sometimes experienced after occurrences of severe natural disasters especially cyclones which usually devastate gardens and other agricultural produces leaving affected people with no food and income sources particularly in the rural communities.

The National Health Information System (NHIS) is currently working on improving national health statistics.

2.2.3 Gross Secondary School Enrolment Ratio

The gross secondary school enrolment ratio as available from the Ministry of Education indicates the ratios of 32.4 %, 37.4% and 35.4% for the years 2006, 2007 and 2008 respectively, compared to a UNESCO's figure of 41% in 2004.

2.2.4 Adult Literacy Rate

The national figure for adult literacy rate is quite uncertain as the 1999 national census revealed a figure of 74% while recent statistics indicate another figure of 66%. The decision to include Vanuatu as eligibility for graduation was based on the 1999 census figure of 74%. Again the question of consistency and reliability is of great importance to determine Vanuatu's eligibility for graduation.

On the overall, a country must score an index of at least 58 to be included in the list of LDCs and a threshold index of 64 to be eligible for graduation. On the overall, Vanuatu scores a human asset index of 66 making it eligible for graduation from its LDC status. However, the question of data consistency and reliability on the above indicators is of paramount importance to determine whether Vanuatu is really eligible for graduation or not.

2.3 Economic Vulnerability Index (EVI)

This criterion reflects the risk posed to a country's development by external shocks and uses seven indicators, which include;

- Population size,
- Remoteness,
- Merchandise export concentration,
- Share of agriculture, fisheries and forestry in GDP,
- Homelessness owing to natural disasters,
- Instability of agriculture production, and
- Instability of exports of goods and services.

According to the criteria, the threshold for inclusion in the list of LDC is 42 and the threshold for graduation is 38. The last triennial review of the status of LDCs shows that Vanuatu scores a very high EVI figure of 64.3. This implies that Vanuatu is a high risk country in terms of its exposure to external shocks and therefore hindering the development progress plus posing other structural problems.

3. Our Development Challenges

Though much has been achieved during the past twenty nine years of independence in terms of development, there are still major hurdles which the country must unavoidably face in pursuit of our development objectives. While some of our challenges could be addressed through policy interventions, others are fixed in nature, especially those related to the geography natural disasters.

3.1 Isolated and mountainous Islands

Vanuatu has around 80 mostly volcanic islands, most of which are quite mountainous and as a result, most people live on the low coastal areas where the land is more flat and fertile for farming. The mountainous state of these islands poses a great difficulty for infrastructure development therefore some of the parts of the islands are inaccessible by road. For these areas, the only mode of transport is by sea so settlements have to be located on the sea coast. The high terrains provide easy access for surface run-offs which during rainy season can cause devastations to infrastructure works and farmland in the lower plains.

Geographically, the islands are scattered apart and the only mode of transport is either by sea or air. Furthermore, some of the islands are very remote that the only economical mode of transport to them is by sea and currently these islands have average ship calls of

one every three months, thus, impacting on the supply of goods and services to the inhabitants.

3.2 Small Market and High Cost of Doing Business

The geographical nature of the country coupled with the small size of the domestic markets for goods and services makes it difficult to attain economies of scale. The major markets for goods and services are confined to the two major urban centers, mainly Port Vila while in the outer islands markets are quite small and fragmented. Access to market is a big problem for most of the farmers in the rural areas because of the lack of proper infrastructure and adequate transport services. Consequently, most rural dwellers only produce to for subsistence purposes, hence, the productive capacity of the rural economy is under utilized.

The domestic financial system is small, less developed and dominated mainly by the activities of the commercial banks. The banking system is very liquid, yet access to credit has been quite difficult in the past due to stringent credit conditions imposed by the commercial banks. With the introduction of a new commercial bank in 2008, there are been some improvements in terms of credit access due to increased competition by banks, but mainly confined to the two major urban centers. Non-formal financial institutions such as micro-finance institutions and private money lenders also offer financial services to those that could not access funds from the commercial banks, however, rates are comparatively high and as a result private sector growth pattern has been very weak in the rural areas where the eighty percent of the population dwells.

The cost of utilities services are also comparatively high, contributing to the high cost of doing business in Vanuatu.

3.3 Vulnerability to Natural Disasters

Vanuatu has been ranked as one of the highly vulnerable country in the Pacific region due to frequency of natural disasters and external economic shocks that hinder the development progress of the country. Some of the factors that contribute to the high economic vulnerability of the country are discussed below.

3.3.1 Earthquake Risk

Earthquakes are frequent in Vanuatu. Between 1961 and 1982, about 4000 earthquakes of magnitude greater than 4 on the Richter scale have been recorded by the USGS. The last major earthquake occurred in January 2002 and was located 35 km west of the capital Port Vila. Reaching 7.3 on the Richter scale, this earthquake caused widespread damage to buildings and infrastructure. Some of the consequences of this episode are still being felt in 2004. Some fault movements have in the past produced changes in shoreline

elevations of up to two metres as islands have tilted. Destructive tidal waves (tsunami) occur occasionally as the result of earthquakes. The last tsunami, which resulted in approximately twelve fatalities, occurred in November 1999, following a 7.3 earthquake located near the island of Pentecost.

According to an ORSTOM study in 1983, the islands with major earthquake risk are the Torres Islands, Santo, Ambae, North Malekula, Maewo and Pentecost because of the frequent occurrence of strong shallow earthquakes.

3.3.2 Volcano Risk

Vanuatu currently has nine active volcanoes, the most dangerous are Mount Garet (797 m) located on the island of Gaua in the Banks Group and Manaro in Ambae. The increased volcanic activity in Lake Manaro in late 2005 has led to a temporary evacuation of people away of the vicinity of the volcano and the island. The total cost of the evacuation was estimated to be around USD 446,000.

The islands with past major evacuations of people due to high volcanic risks included Ambrym 1913, Lopevi in 1970, Gaua island in 1973 and Ambae 2005. (Gaua and Ambae were temporary evacuations).

Volcanoes are a well identified natural disaster risk in Vanuatu. In islands where volcanic activity constitutes a real danger, the population has been evacuated. In other areas, a monitoring network has been organised in cooperation between the Department of Geology and the IRD based in Noumea (New-Caledonia).

3.3.3 Cyclonic risk

Cyclones are very common to Vanuatu and can cause extensive damage compared to other natural disasters because more islands can be affected at one cyclone event. Historical figures show that the average cost of damages caused by cyclones exceeds that caused by any other disasters.

Cyclone season starts from November to April the following year. On average, Vanuatu experiences 2.6 cyclones per year and one can expect a cyclone-free year once every seven years. The largest and most destructive cyclone to hit Vanuatu in recent times was Cyclone Uma in 1987, which 48 killed, 48,000 people were affected and the total cost of damage was around USD 25 million. The last cyclone to hit Vanuatu was Cyclone Ivy in 2004 which killed two people, caused injuries to 8 and the total number of people affected was 54,000. Table 1 below shows the year and dates of cyclones affecting the country since 1981.

Table 1: Major cyclones passing through Vanuatu during 1981 – 2004

Year	Name
1981	Cliff / Gyan
1982	Kina
1984	Beti
1985	Eric, Nigel, Odette, Gavin, Hina
1986	Keli, Lusi, Alfred, Osca, Patsy
1987	Uma, Veli, Yali
1988	Anne, Bola, Dovi, Eseta
1989	Delilah, Harry, Ivy, Lili
1991	Lisa, Tia
1992	Betsy, Daman, Esau, Innes, Fran
1993	Prema, Rewa
1994	Serah, Theodore, Troma, Usha, Vania
1996	Zaka, Atu, Beti, Fegus
1997	Drena, Freda, Ian
1998	Susan, Katrina, Yali, Zuman
1999	Dani, Ella, Frank
2000	Iris, Jojo
2001	Paula, Sose
2002	Zoe
2003	Beni
2004	Ivy

Source: Vanuatu Meteological Services

3.4 Narrow Export Base

Vanuatu's comparative advantage in terms of trade hinges mainly on the low valued primary sector commodities such as copra, cocoa, beef and kava. On the other hand, Vanuatu depends highly on higher valued imports, most of which are manufactured items resulting in rising trade deficits in the recent years due to the increased absorptive capacity of the domestic economy.

Vanuatu's total commodity exports remain quite volatile. For instance, in 2007, it fell to VT2,229 million from VT3,651 million a year earlier. Some of the factors which contributed to this high volatility include;

- Supply shocks relating mainly to effects of natural disasters mainly cyclones,
- volatility in world market prices and domestic prices,

The narrowness of the export sector coupled with the vulnerability of the primary sector

to supply shocks continues to shape the export trend as indicated by the figures in table 2 on the next page.

Table 2: Vanuatu export commodities (Million Vatu)

Commodity/Year	1999	2000	2001	2002	2003	2004	2005	2006	2007
Copra	1,384	1,096	323	174	282	446	126	324	485
Coconut Oil	-	126	362	471	382	1,026	733	193	492
Beef Veal	404	380	239	194	287	286	302	332	180
Cocoa	148	147	64	141	295	160	181	277	221
Shells	76	107	95	50	45	30	57	92	24
Timber Sawn	363	415	334	197	249	247	203	306	80
Cowhides	27	47	39	28	36	28	43	33	19
Kava	379	478	503	230	228	440	477	698	442
Coffee	2	-	5	1	-	-	-	-	-
Vanilla	-	4	4	15	34	33	15	8	10
Coconut Meal	-	11	41	62	93	117	85	6	3
Root Crops	-	3	3	14	38	47	39	19	17
Live Cattle	-	-	44	60	52	62	56	-	-
Other Products	124	400	246	349	580	371	592	1,661	255
Total	2,907	3,214	2,302	1,928	2,600	3,293	2,909	3,651	2,229

Source: National Statistics Office

Copra, which was once earning some VT1,384 million in 1999 but only managed to earn VT485 million in exports in 2007, a drop of around 184%. Interestingly, our national statistics does not show any high export figures for tuna and nor recording any export vessels as reported in the CDP report.

3.5 Our Fragile and Narrow Income Base

Given the highly vulnerable status of our economy, so is the vulnerability of our incomes both in the rural and national levels.

3.5.1 Irregular Rural Income Flows

Most people in Vanuatu live in the rural area and their main means of income is mostly through the primary agricultural commodities, including copra and kava. They also involve root crops, fruits and vegetable farming mainly for subsistence purposes, the excess of which are sold in the local markets. Fishing is mainly done for subsistence purposes and in Vanuatu it is a sector which still needs to be further explored and enhanced.

Thus, the lower level of economic activity in the rural areas implies that cash earnings are usually irregular depending on the income opportunities that may arise. Furthermore, earnings are also tied to the commodity prices which means that during times of high

prices, production would increase while during periods of low prices, production also subsides. The main reason being that most rural farmers are small scale holders and are usually price takers, implying that they will only increase production when price increases because of the high fixed cost of production relating mainly to transport.

The occurrence of natural disasters in the country also greatly affects the production of these agricultural commodities in the short to medium term.

Furthermore, income opportunities are very limited in the rural areas mainly due to the fact most economic activities are confined to Port Vila and Luganville.

3.5.2 Narrow Government Revenue Base

Given the smaller resource base of the country, the Government has only a limited number of revenue options to choose from. The major revenue earners for the Government are currently VAT and import duty, both of which contributed around 56% to Government's total revenue and grants in 2007. The foreseen risk is that as Vanuatu starts accession to various regional and global trade agreements, earnings from import duty could decline.

In terms of revenue source, much of the inflow is from the services sector of the economy such as tourism, wholesale and retail trade and transportation. However, given the global economic downturn, we could expect the activities in the sector plus other sectors of the economy affected with the possibility of a decline revenue collections.

3.5.3 A Fragile National Output Base

A detail breakdown of the Country's gross domestic product indicates that the services sector of the economy contributes around 77% in 2007. Wholesale and retail trade and tourism activities contribute to some large extent in this percentage. In fact, the good economic performance has contributed a lot to buoyant overall economic performance in the recent years.

However, the risk is that this sector is quite vulnerable to economic shocks that it could have rippling effects on other sectors of the economy including government revenue.

Given the current global economic downturn, it is quite possible that this sector could be affected. Hence, the Government feels very strongly that Vanuatu be excluded from this year's triennial review until the full impacts of the crises are assessed.

4.0 Why it is too early for Vanuatu to graduate from an LDC status

Based on the above arguments, the Vanuatu Government maintains its position that it is quite too early for the Country to graduate from its LDC status. Thus, until the following issues and challenges are addressed sufficiently then we will be eligible for graduation.

4.1 Data Discrepancies

Data discrepancy is quite a problem in Vanuatu as revealed by various data inconsistencies in UN reports concerning Vanuatu LDC status. As mentioned earlier on, statistics used in some of the indicators for the Human Asset Index are needed to be verified or even updated so that any decision on Vanuatu's LDC status is based on concrete numbers that are approved nationally. The National Statistics Office planning to undertake another national population census this year and statistics derived from this would be useful in updating the relevant indicators so that future decisions are made on more reliable and most recent statistics.

4.2 Impacts of Current Economic Global Downturn

Because of the highly vulnerable nature of the economy, economic shocks due natural disasters or international market downturns tend have some extreme effects on the domestic economy. Hence, as a result of the current global crises, already commodity prices have plummeted, affecting Vanuatu's exchange earnings through exports. On the other hand, the current high import demand continues to put pressure on the country's official foreign reserves which is currently earned mainly through donor funds.

On the output front, the services sector is seemed to be likely to be affected because of its direct linkage to the international markets. Any negative effects on this sector implies and consequential effects on the overall economic output.

Therefore, the Government feels that the next triennial review for Vanuatu be postponed until the impacts of the global crises has been fully assessed.

5.0 Way Forward

While awaiting the UN's decision yet to be made on Vanuatu's LDC status, the Government is currently undertaking measures to address some of the issues raised in this report along the following areas.

5.1 Data Discrepancies

The Government through the National Statistic Office is currently working on a four year strategic plan and work program to address the issue of data gaps and inconsistencies in preparation for the next triennial.

5.2 High Economic Vulnerability Status

The Government still maintains its stance that the economy is highly vulnerable; therefore graduating from the LDC status may not solve the nation's development challenges in the long- run.

Along with other LDC countries which are currently recommended for graduation, the Government is planning to make a presentation on the country's stance at the next UN General Assembly.

5.3 In Country Visit of the Evaluators

Before a final decision is made on Vanuatu's graduation, the Government would like to invite a team of evaluators to the Country for a further assessment of the issues raised.

6.0 Conclusion

With the above arguments, the Government maintains its stance that it is quite too early for Vanuatu to graduate from its LDC status. Therefore, the Government feels that it would be more appropriate that the CDP reconsiders its recommendation for Vanuatu's graduation.

Background paper on the 2009 AMR theme on Global Public Health (Preliminary draft of CDP Policy Note)

I. Introduction

The main objective of this report is to contribute to the Economic and Social Council debates on global public health. It examines how international cooperation—with emphasis on global health partnerships (GHPs)—supports developing countries in achieving the internationally agreed goals in health, including those in the Millennium Development Goals (MDGs). Health outcomes are the result of complex interactions of a wide range of factors. The Committee opted to focus its analysis on the overarching theme of inequality of health outcomes—both across and within countries—and to examine the role that global health partnerships have played and can play in alleviating health inequalities.

GHPs are a new form of alliance among public and private institutions and agencies (including national and international organizations, civil society organizations, philanthropic foundations and private companies). Their objectives are, among other things, to contribute to the eradication of specific diseases and the mitigation of their negative impact in developing countries as well as to expand actions and resources with the aim of attaining the internationally agreed development goals in health. But GHPS' approaches in recipient countries may not address or even further deteriorate existing inequalities in health. Most GHPs claim to be pro-poor, but they do not appear to have specific indicators for their equity aims. In fact, there are concerns about whether anti-poverty and gender equality approaches are sufficiently integrated into the GHP practices.

This report will identify the factors underlining the persistence of inequalities in health and the impact of health policies on the internationally agreed health-related goals, including the MDGs, through "the inequality lens". It will then examine whether and how new approaches for development cooperation embodied in the GHPs -- alliances among public and private entities-- have an impact on health inequalities and recommends ways in which GHPs or other formats of international aid can help reduce health inequalities.

Finally, it will make recommendations on how the international community can further assist developing countries to improve the health status of their populations.

Why do health inequalities matter for achieving the MDGs and other health-related globally agreed goals?

First, large inequalities in health that exist between the developing and developed worlds demonstrate that health attainments in developing counties remain unsatisfactory, despite successes in many fronts. A significant share of the populations of many developing countries suffers from preventable and/or easily treatable diseases. Gaps in health outcomes also indicate how far the international community, including Member States, still has to advance to provide adequate health services for all. Even in developing countries with mortality and morbidity patterns similar to those of developed countries, health outcomes remain below those attained in the developed world.

Second, health inequalities within nations – in not only in developing, but also in developed countries[1]-- are often as great as, or even greater than, inequalities across countries. This has significant implications for achieving the internationally agreed Goals. In the absence of well targeted efforts to provide necessary health care services for worse-off groups (such as the poor, people living in remote areas, a particular gender or an ethnic group), achieving a particular *average* target does not necessarily indicate that living conditions *of all* have improved. The capability of health is arguably the most important, being a precondition of all other capabilities: where health inequalities are large, the poor is most likely to be experiencing other types of inequalities in, for example, education attainment and access to safe drinking water and decent work. Consequently, because the objective of the internationally agreed development goals, including the MDGs, is to improve the situation of the worse off, achieving national goals solely on the basis of average health status is not be enough.

Third, inequalities in health reflect the interplay of cultural, political and economic forces, including the frequency, lengths and depths of conflicts as well as other severe adverse shocks (natural disasters, for instance) that a country or a region experiences. Development partners need to ensure that their programmes take account of and address the existing inequalities. When aggravated, inequalities – not only in health, but also in other fronts – can become a source for social unrest or conflict. Such considerations go beyond narrowly focused efficiency or effectiveness objectives of aid policies.

The above considerations are consistent with the main conclusions and recommendations of the recent report by the Commission on the Social Determinants of Health[2]. The Commission indicated the urgent need to improve daily living and working conditions for better health outcomes, which requires tackling the inequitable distribution of power, money and resources. Inequity is shaped by social structure and processes that need to be changed.

II. Conceptual considerations

Health is a concept that incorporates many aspects of the life of the individual and the structure of a society. Different persons and communities have diverse ideas and aspirations about a desirable outcome of health at the societal level. Some clarification of the health-related concepts and definitions to be employed in this report is in order before examining health inequalities.

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[1] For example, life expectancy in a part of Glasgow, the United Kingdom, at 54, is below the average life expectancy in India; in the United States, equalizing the deaths between African and white Americans in the 1990s would have averted five times more deaths than achieved by medical advances over the period. In some developed countries, gender inequalities in health are as great as or even greater than in some developing countries.

[2] Commission on Social Determinants of Health (2008), Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health (Final Report of he Commission on Social Determinants of Health (Geneve, WHO).

Equality or equity?

Although sometimes used interchangeably, *inequality* and *inequity* are different concepts, wherein the latter incorporates an assessment of fairness based on ethical idea. This distinction is particularly important in health where equality does not mean achieving the same state of health. There are natural inequalities in health that may not be considered unfair. For example, as people age – both male and female -- their health tends to deteriorate and it would be unreasonable to expect individuals in all ages to have equal health. Some ethnicities are prone to specific diseases, while other illnesses are particular to a specific gender (haemophilia in males, for instance). There are a variety of other genetic advantages or disadvantages which need to be taken into account when deciding what an equitable distribution of health is. Equity is, thus, the relevant concept for health policies, but not equality per se. Achieving complete equality of outcomes in health may not be a possible policy objective; equity in health seems to be a more relevant objective.

Equity is an ethical concept with no universally agreed meaning. Equity is necessarily required to achieve equality of outcomes among groups or individuals who are similar from a genetic/age/sex/perspective. But it is not a sufficient requirement for achieving health equity in a given society because it allows large disparities in health outcomes between different groups. In this regard, it is up for individuals in each society/nation to define what they consider as desirable with respect to the distribution of health and what they expect from their governments in terms of achieving those goals. The examination of these issues, however, is beyond the scope of this report. This report adopts a simpler approach and regards that large inequality in health outcomes, which exist in many countries and across countries, are generally undesirable.

Health is multidimensional

The second point of clarification relates to the outcomes with which the paper is concerned. Health is a multidimensional concept incorporating aspects which can be affected by structures and policy. Dimensions of health may include the quantity of life (i.e. life expectancy and mortality rates at different ages), as well as factors related to quality such as morbidity, nutrition, psychological and social well-being. Common measures of health outcomes include mortality rates, the prevalence or incidence of particular diseases, anthropometry, self-rated health; process indicators such as child immunization coverage, availability/accessibility of healthcare services; and health behaviours such as smoking, diet and physical activity. The presence of inequities in one dimension does not necessarily correspond to the existence of inequities in another. For example, a community may have an inequitable prevalence of heart disease across different ethnic groups, despite equitable access to healthcare services. Depending on which aspect of health to look at, one may reach a different conclusion. It is thus important to be explicit about what outcomes or processes are being (or not being) assessed.

Horizontal inequalities

The most common measures of inequality with respect to health are of vertical inequality, or inequality among individuals or households, while horizontal inequality is concerned with inequalities that may exist among groups, with the relevant groupings depending on the historical, social and economic context. The literature on health inequalities spans inequalities between racial/ethnic groups, class (as determined by occupational type), education, income, religion, or geographic area (rural/urban, North/South etc.). Often, there are considerable overlaps between these classifications since individuals generally belong to more than one group at any one time. There are also 'natural' as opposed to social groupings, such as gender and age, which may suggest differential biological characteristics. Of most concern are those systematic disparities in health outcomes among socially constructed groups which do not have any biological basis and imply inequity as well as inequality.

III. Evidence of health inequalities

The current state of data collection on health, particularly in developing countries, is not adequate. Analysis, therefore, faces severe limitations. Many countries do not possess adequate capacity for collecting data on health. Owing to financial and administrative constraints just a few low-income countries are able to maintain death, birth and disease registries. Censuses and vital registration systems are non-existent in many countries. Even when survey data are available, their validity – i.e. measuring what it is supposed to measure – is sometimes questionable due to crude tools and methodological approaches employed.[3]

Because the lack of reliable vital statistics data on health status and data by different social groups, data presented here should be considered preliminary. Despite these limitations, the available data do provide useful estimates or yardsticks of the health status of the population. Monitoring changes in health status and inequalities within a population over time allows policy makers to devise health policies to advance public health status and to enhance equity.

Defining the appropriate groups within a given country is an important consideration when examining health inequalities. Groups should be established according to the objectives of the analysis being made. Yet, as mentioned before, groupings interact and overlap with each others, making it difficult to single out the impact of a given intervention on the heath status of a particular group. Geographic location is a case in point. Geography is often considered as a factor underlining inequality, but it can also be a proxy for differences across ethnic or religious groups in some countries. For instance, the concentration of people sharing same ethnic or religious background in a given region may also become a factor contributing to inequality (between that region and the rest of the country) besides location and/or difficulty of access. Additional information is thus

[3]Attaran, A. (2005). "An immeasurable crisis? A criticism of the Millennium Development Goals and why they cannot be measured", *Plos Medicine*, vol. 2, Issue 10 (October), pp. 955-961.

needed to distinguish the effect of each factor on the outcome, as inputs to identify what additional policies or interventions should be introduced to increase equality.

The health status of the population reflects many aspects of the social and natural environment in which "people grow, live, work and age"[4]. Some aspects can be local, such as traditional social norms and hierarchy, while others are global. Climate change – changes in atmospheric environment at the global level -- has recently been recognized as significant and emerging threat to health.[5] Its (in-)equity is fundamentally determined by the global and national structures of social and economic hierarchy and the socially created conditions that dictate health. A single indicator could hardly capture the multi-dimensionality of health, and an array of information about health status and health system inputs must be analyzed carefully to assess health inequalities and their trends over time. Moreover, different indicators often lead to different—even contradictory—assessments when monitoring changes in inequality status over time.[6]

In addition, it is important to select appropriate statistical method to measure the extent of inequality and to assess changes over time. The magnitude of health inequality across different social groups can be summarized by, for example, calculating ratios or rate differences (e.g., between the average or top quintile and lowest quintile), or more complex numerical manipulation of data to characterize the degree of inequality of health status (e.g., Gini coefficient and generalized entropy). Choices are numerous and there may not be an objective criterion *a priori* that can be used to select a particular approach or a specific indicator for a specific purpose.

A. Health inequalities across countries

Large inequalities in health exist between the developing and developed countries, not only in health outcomes, but also in the supply of health care services and how such service are financed by public and private agents (see table 1). It is well known that disparities in health outcomes is wide between these two groups of countries, such as existing differences in terms of under-5-mortality rate and life expectancy at birth. Disparities are also considerable in terms of the amount of resources devoted to health—not only in absolute but also in relative terms— as well as in terms of the share of health expenditures that are financed by individuals these expenditures. Low income countries can only afford to spend a small portion of their total income on health and their populations have to cover a large share of their medical expenses out of their own pockets. These facts demonstrate that health attainments and services in developing counties remain unsatisfactory, despite successes achieved in many fronts. Not surprisingly, a similar pattern is observed across different levels of education attainment

[4] Commission on Social Determinants of Health (2008), op.cit., p. 42.
[5] Confalonieri, Ulisses et al. (2007), "Human Health", in M. L. Parry et al. (eds.), *Climate Change 2007: Impacts, Adaptation, Vulnerability, Contribution of Working Group II t the Fourth Assessment Report of the Intergovernmental Panel and Climate Change* (Cambridge U.P., Cambridge), pp. 391 – 431.
[6] While this report largely employs statistical methods to characterize inequalities in health, there is a useful visual approach to characterize level of public health and inequalities in health. Such approach, however, requires more data points on different socio-economic groups than currently available in many developing countries, thus not readily prepared.

of the mother because wealth and education levels are positively correlated. Except Zimbabwe, children whose mothers have lower educational attainment are less likely to survive by age 5.

Inequalities within countries are considerable. Table 2 shows the numbers of countries whose ratios of under-5-mortality rate (U5MR) between lowest and highest wealth quintiles belong to a specific range. Except for one country (Chad, which has one of the highest U5MR at any wealth quintiles in the world), children born in poorer families are facing higher probability of dying before reaching age 5.

Some developed countries also show health inequalities across different levels of education attainment. In Europe, health inequalities across education attainments vary considerably, and education levels are statistically significant in explaining health inequalities in all countries. For example, the Czech Republic, Hungary and Poland the ratio of death rate (i.e., the ratio to total death to population in a group or community) between lowest and highest quintile of achieved education is more than 4, while in Spain, Sweden, Norway, Denmark and Belgium, the ratio is under 2.

Health inequalities are also present between male and female across countries. It is well known that female has a longer life expectancy at birth, irrespective of income levels (see table 3). Differences of life expectancy between both sexes, however, become less pronounced when health-adjusted life expectancy is estimated, because women are prone to be unhealthy for longer periods of time before they die. Gender-based health gaps can also be observed at birth owing to the strong preference for sons in some countries (see table 4). The preference for sons is deeply rooted in a few Asian countries, notably in China, India and the Republic of Korea. While India has 1.08 sex ratio, slightly above world average, some states in India have been reported that male-female ratio at birth was as high as 1.29 during the period 1999-2001.[7]

One of useful way to assess inequalities is by **visually** plotting the data. Health distribution trends are varied, but could be grouped into three main patterns, as illustrated on Figure 1:

(i) "mass deprivation", when the majority of the population has equivalent but very limited access to health care services, while a small privileged class finds ways to obtain the care it needs;

(ii) "queuing": general access to health services is better than in case of the mass derivation, but middle-income and upper-income groups benefit most, while poorer groups are still suffering; and,

[7] Sharma O. P. and Carl Haub (2009). "Sex ratio at birth begins to improve in India", Population Reference Bureau, available at http://www.prb.org/Articles/2008/indiasecratio.aspx?p=1 (retrieved on 15 January 2009).

(iii) "exclusion" the majority of the population has reasonable access to services, but a poor minority of the population is deprived, relative to the other groups.[8]

Figure 2 shows patters of the distribution of U5M rates in 8 developing countries. Niger appears to fit the mass deprivation pattern. Queuing characterizes patterns in Namibia and Uganda (though at different levels of overall U5M), while exclusion would describe trends in Colombia and India. Trends in the remaining countries are less clear: for example, Cambodia's pattern is similar to mass deprivation, but at lower levels of U5M than in Niger. Admittedly, these are simplistic characterizations of the distribution of health outcomes in a given country. When such graphic representation is available over time, they do provide useful information on how health interventions affect different socio-economic groups differently and point out the effectiveness of a certain intervention on health of the poor or the disadvantaged.

The figures and tables presented above show some aspects of health inequalities across countries at a given point in time. How about the trends in health inequalities over time? Trend analysis requires at least two different data points and only a handful of developing countries conducted health surveys whose results are comparable at two or more different points in time.

Figure 3 shows the coverage of three doses of vaccine against Diptheria, Pertussis and Tetanus (DTP3) in urban and rural areas for the period 1985 – 2005 in select developing countries. Bangladesh, Egypt and Senegal not only improved the immunization levels in both urban and rural areas, but also narrowed the urban-rural gap, with the latter two countries having achieved parity between the two areas. Tanzania appears to have positive trends, improving the level both in urban and rural areas, but the gap between the areas remained. In Colombia, the immunization levels have been flat over time with no obvious trends in urban-rural gap. While the coverage declined both urban and rural areas in Indonesia between 2000 and 2005, the urban-rural gap improved slightly simply because the rate of decline in the urban area was larger.

Figure 4, in turn, depicts trends of stunting in families whose mothers have no education and those with secondary education. While stunting ratios declined for both groups in 4 out of the 6 countries, only the Dominican Republic has been successful in significantly narrowing the health gap associated with educational attainment.

It is interesting to note that DPT3 coverage improved in the majority of the sample countries while stunting ratios between two different educational groups in the countries in figure 4 display mixed results. In two countries, the ratio widened; three countries experienced improvement and one country presented no clear trend. Disparity between the two groups has been more persistent in the stunting case than in the immunization

[8] Van De Poel, E., A. R. Hosseinpoor, N. Speybroeck, T. Van Ourti, and J. Vega. 2008. Socioeconomic Inequality in malnutrition in developing countries. Bulletin of the World Health Organization **86**:282-291.

coverage. In fact, stunting is considered to be a better indicator of health outcomes than vaccine coverage because it measures the combined effects of different parameters in the health systems. Malnutrition, such as stunting, reflects chronic problems and hence the deficiency of the on-going efforts related to health systems. Nutrition is not only about food in-take, but also reflects health care, life styles and the environment in which people live and work. Immunization coverage, on the other hand, can be improved by discrete interventions. Overall improvement in the immunization coverage in the sample countries can be attributed, to some extent, to the implementation of global health programmes and partnerships (discussed below) introduced to achieve the health-related goals and targets in the Millennium Development Goals.

B. Health inequalities and the Millennium Development Goals

How do changes in health inequalities among different socio-economic groups relate to progress towards achieving the health-related goals and targets in the MDGs? Health-related targets are often linked to the overall achievement of a nation, thus reflecting only an average. Overall progress towards the health-related targets can be made while health inequalities among different socio-economic groups persist or even deteriorate as some groups may be left behind or may not necessarily benefit to the same extent as the relatively more affluent or privileged. In particular, a major effort by official donors and global health partnerships (GHPs) to transfer resources to improve health in developing countries would better attuned with the spirit of the Millennium Declaration if its programmes and projects explicitly incorporate in their objectives the reduction of inequalities in health and other pertinent areas.

As an illustration, table 5 presents data on under-5-mortality rate (U5MR) for 22 developing countries according to wealth level. The countries encompass high and low mortality situations and accounted for about 27 per cent of the world's population.[9] Despite the wide variation in U5MR across countries, mortality is always higher in the poorest quintile than in the richest. The ratio of the U5MR in poorest to richest quartile of the wealth distribution varies between 1.18 (Tanzania, 1999) and 5.26 (Peru, 2000), and most ratios are within 1.5 and 3.0, meaning that a child born in the poorest family is 50 to 200 per cent more likely to die before reaching age 5 than a child born in a better off family.

Among the 22 countries, 13 reduced overall U5MRs between two surveys in a statistically significant way but in only 4 countries (Colombia, Egypt, Guatemala, and Turkey), the gap between richest and poorest quintiles declined (though not statistically significant).In 5 countries the gap widened.[10] In the remaining 4 countries, reductions in the national U5M had a neutral impact on health distribution.

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[9] Moser, Kath A. et al. (2005). "How does progress towards the child mortality millennium development goal affect inequalities between the poorest and least poor? Analysis of Demographic and Health Survey data", *British Medical Journal*, vol. 331 (19 November), pp. 1180-1182.

[10] In case of Tanzania where overall mortality increased, the increment is not statistically significant.

As noted, "...improvements in national under 5 mortality, in line with the MDG[s], do not necessarily bring about decreasing inequalities in mortality between the poorest and least poor in society. Indeed, such society-wide improvements seem as likely to be accompanied by increasing as decreasing inequalities."[11] In fact, it has been suggested that efforts to achieve the MDGs are likely to increase inequalities with the better-off benefiting disproportionably more than their disadvantaged counterparts, in the absence of a concerted effort to ensure that disadvantaged groups benefit from health service delivery.[12] This is largely because it is often more difficult for the health authorities to extend services to the worse off who more likely live in distant or hard to reach areas. Moreover, reaching some groups require efforts in other areas such as improving communications between local authorities and targeted groups, facilitating increased participation by local communities and greater access to education and information so as to increase people's awareness of health issues, among others.

Evidence on the linkage between policies to achieve the health-related goals in the MDGs and their impact on health inequalities is admittedly scarce. But where available, it indicates the importance of paying attention to health inequalities and their social determinants as well as the need for additional concerted efforts in the implementation of health interventions and other social policies so as to reach the poor and the disadvantaged.

IV. Determinants of health inequalities

The poor health conditions of the worse-off or the socially disadvantaged are, in a broad sense, "caused by the unequal distribution of power, income, goods and services, globally and nationally, ... This unequal distribution of health-damaging experiences is not in any sense a "natural" phenomenon ...".[13] Social (dis-)advantages reflect socio-economic status, gender, ethnicity and geographical area. Social advantages are often the result of social and economic policies, combined with cultural, political and historical factors, natural and "built-in" environment. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequalities between and within countries. The Commission for Social Determinants of Health, for instance, addresses four sets of questions in examining the production of health inequalities in a framework that facilitates approaches to describe and monitor social determinants of health, and consider entry points for action:

> 1) Socioeconomic Political Context: What are the main characteristics of a country that influence the form and magnitude of social stratification as well as

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[11] Moser *et al. op. cit.*, p. 1181.
[12] Gwatkin, Davidson R. et al. (2004), "Making health systems more equitable", *Lancet*, vol. 364 (October 2), pp. 1273-1280.
[13] Commission on Social Determinants of Health (CSDH) (2008). *Closing the Gap in a Generation: Health Equity though Action on the Social Determinants of Health, Final Report of the Commission on Social Determinants of Health* (Geneva, WHO), p. 1.

the implications of stratification for the circumstances in which people live and work?

2) Social Stratification: (i) what are the key dimensions of social stratification?, and, (ii) how extensive is the social stratification?

3) Differential exposures, vulnerabilities, and consequences: What is the extent of (a) differential vulnerabilities, (b) differential exposures, and (c) differential consequences?

4) Differential outcomes in health: What are the main resulting health inequities that emerge in a given society and what is the extent of these health inequities?

A. Health and Socio-economic status, ethnicity and geography

Socio-economic status reflects economic resources (income and wealth), education and occupation. Household wealth is a significant measure of economic resources available for health care and as seen in figure 2, there is a correlation between greater wealth and better health outcomes. Similarly, *education* is also positively correlated to heath. As seen above, the likelihood of stunting in childhood is higher among children whose parents have limited educational attainment.

The type of *occupation* is another factor affecting health outcomes (and itself the result of access to education, wealth of parents, gender considerations, among others). It is partly associated with occupational hazards, but health outcomes also differ according to employment grade or rank. For example, in the UK civil service, the higher the hierarchical grade the lower the mortality rate.[14] Furthermore, there is a strong inverse relation between the grade of employment and absenteeism due to health issues. The type and quality of job can have direct effects on health through occupational hazards, or may affect health indirectly through income security or through chronic psychological and social mechanisms. In the Russian Federation, the increase in mortality among working age adults between 1980 and 2001 have been attributed to "unemployment, alcohol consumption and social stress".[15]

Discrimination against specific *racial, ethnic or religious* groups is known to have serious health and social consequences. In Central and Eastern Europe, the Roma people suffer deprivation. In Bulgaria, for example, their life expectancy at any age is 5 to 6 years below the rest of the population, while the infant mortality rate is six times the national average. In Hungary, infant mortality among the Roma is nearly four times the

[14] Marmot, Michael, G. (1999), "The importance of psychosocial factors in the workplace to the development of disease", in M. G. Marmot and R. G. Wilkinson (eds.), *Social Determinants of Health* (New York, Oxford UP). **CHECK**

[15] Murphy, Michael et al. (2006). "The widening gap in mortality by educational level in the Russian Federation, 1980 – 2001", *American Journal of Public Health*, vol. 96, pp. 1293-1299.

average for the country while, in Romania, it is two-and-a-half times.[16] In Indonesia in 1995, mortality among non-Javanese children was 36 per cent higher than among Javanese while non-Chinese children had mortality rates nearly four times as higher as the rate observed among Chinese children (who are likely to be wealthier). Child mortality rates among non-Tagalog speaking population were 33 per cent above those of Tagalog speaking in the Philippines and that of non-Christians 47 per cent above that of Christian (who are more likely to be wealthier, again). In Latin America, the prevalence of diarrhoea among children and maternal mortality are higher among indigenous people than among non-indigenous.

Health inequalities also occur across *space*, partly owing to natural differences in the risks and exposures in different geographic contexts as well as to differences in the availability of and quality of services rendered by health care facilities. In South Africa, the Eastern Cape and the Northern Provinces have the highest prevalence of stunting. The same areas are also the two provinces with the highest rates of incidence of poverty in the country. In the Chandigarh Union Territory in India, about 68 per cent of the birth deliveries were not assisted by a skilled attendant (such as nurse, mid-wife or doctor) in the slums, compared with 21 per cent and 7 per cent in rural and non-slum urban areas, respectively.

The way societies are stratified are are often conveniently summarized using the acronym "PROGRESS": Place of residence (urban/rural), Race/ethnicity, Occupation, Gender, Religion, Education, Socio-economic status and Social capital/resources.[17] So far, the report has examined 7 out of 8 social determinants. Gender is analysed in the next section.

B. Health inequalities between women and men

Gender is socially constructed, while genes usually only determine if individuals are female or male. Gender inequity is a key variable in the policies, economics and politics of health. Gender differentials manifest directly in health status, as well as in access to health care, in health research and in the quality and kinds of health services provided. Furthermore, gender inequities work in a manner that interacts with other types of inequalities arising from the factors examined above (such education, income, etc.). In fact, the gender factor persists as a strong determinant of health including in the more equal and affluent societies. The costs of not attending to the effects of gender while responding to global health challenges are immense. They include:

> Neglect of diseases and health problems facing women e.g. numerous physical and emotional ill health problems arising from socially normalized gender-related practices such as sexual abuse and violence against women and girls, female genital mutilation, illicit abortions, child marriage, sex trafficking,

[16] UNDP (2005). *Roma: Human Development, Challenges and Opportunities* (New York, UNDP).
[17] Evans T. and H. Brown (2003). ":Road traffic crashes" operationalizing equity in the context of health sector reform", *International Journal of Injury Control and Safety Promotion*, vol. 10, vol. 1 &2, pp. 11-12.

Slow diagnoses and treatment of diseases and conditions that specifically affect women, e.g. breast and cervical cancer, STD's, endometriosis and others.

Inattention to social factors causing women's ill health – occupational hazards in the various places that women work, overwork and stress, inequalities in remuneration and economic insecurity, insecurity arising from sexual harassment etc.

Gender inequities, although overwhelmingly common in relation to women, may also be noticeable against men in some particular circumstances. For example, that average life expectancy fell in the Russian Federation in the 1990s and the decline was sharper among men than women. Between 1990 and 1994, life expectancy for Russian men declined from 63.8 to 57.7 years (6.1 years decline) and women from 74.4 to 71.2 years (3.2 years decline).[18] Tobacco and alcohol abuse and psychological depression— probably related to job losses— are among the many factors that accounted for the disparities in life expectancy between men and women during the period.

Gender inequalities in health reflect a complex interaction of social and biological variables. Yet because they tend to be dismissed as 'biological differences', social responsibility is denied, and gender differences in health are therefore not often treated seriously in social policy (Sen et al. 2002). A gender approach to health distinguishes between biological and social factors, and examines their interactions. When it comes to the social factors, a gender approach to health does not just address ascribed 'gender roles' of women, but also addresses the structural inequalities between women and men in access to money, education, resources, jobs, and services including health services

(i) Gender-related health inequalities and the MDGs

The international development agenda pays particular attention to issues of gender inequality and empowerment of women. The MDG 3 specifically commits to achieve gender equality in many socio-economic, political and cultural areas. Reflecting the linkages among these elements, other Goals have specific gender-related targets in education and health, for instance. But much more needs to be done to mainstream gender into global health policy. For example, in some countries reducing infant mortality requires attending to the factors that lead to significantly higher mortality rates among girls than among boys, despite the greater biological vulnerability of boys at birth. Meeting MDG-5, the improvement of maternal health, which addresses one particular aspect of women's health, also have significant implications for the MDG 3. Maternal mortality is strongly correlated with women's unequal access to adequate nutrition and education, exacerbated by curbs on women's mobility that limit access to antenatal and obstetric emergency treatment. WHO further observes that vulnerability to gender-based violence by partners during pregnancy is a causal factor in maternal mortality[19] (see Box 1).

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[18] Notzon, Francis et al. (1998), "Causes of declining life expectancy in Russia", *Journal of American Medical Association*, vol.279, No. 10 (March), pp. 793-800.

[19] WHO (2002). *World Health Report 2002*, Geneva: WHO.

The MDG 6 – combating HIV/AIDS, malaria and other diseases– demands particular attention to the fact that gender inequalities are implicated in the epidemiology of the HIV/AIDS pandemic and the policy responses and services, in addition to the burden on women and girls generated by widespread sickness and fatalities. The gender dynamics in HIV/AIDS include unequal sexual relations and the fact that women are often unable to exercise choice and maintain physical integrity in the context of war and conflict, extreme poverty and in many societies where women cannot control their own sex lives, let alone insist on the use of condoms. In such situations, the "abstain, be faithful, condomise" (ABC) approach has little practical value.

Overall the global health policy context is one in which the mainstream remains largely inattentive to gender as a major determinant of health. Women rely more than men on public sector provision, and inherit the care burden when public services are eroded. Since the introduction of structural reforms in the 1980's began to erode many of the global gains of the 20th century, and to constrain the development of comprehensive public health systems, the challenges of addressing inequalities in health have intensified. Not only are gender inequalities likely to persist, but the fact that women and girls bear the bulk of the care burden, poses an additional challenge in the context of inadequate or non-existent public health services.

(ii) Health inequalities and environmental factors

In addition, environmental factors, some of which are stated in the MDG 7, can also contribute to health risks of women, thus widening health disparities between women and men. A case in point is the health implications for women of widespread dependence on traditional bio-mass fuels for domestic energy.[20]

Women are found to suffer disproportionately more than men from acute respiratory infections (ARI) and acute lower respiratory infections (ALRI) in addition to chronic obstructive pulmonary disease (COPD). They also face greater risk of lung cancer, and cataracts leading to blindness. Women's mortality risk from smoke-related infections is assessed to be 50 per cent higher than for men. Sixty percent of the noted 1.6 million deaths annually due to inhaling fuel smoke from cooking indoors are of women (Modi et al, 2005:28). Pregnant women also risk having still births and low birth weight babies, with associated intergenerational effects on the child's life chances and future health[21] (see box 2). In addition, fuel collection is primarily women's responsibility, and fuel shortages—besides having negative implications for good nutrition-- add to women's already long working day. This again can have adverse health effects directly for women but also indirectly for children left behind for long periods without the main caregiver.

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[20] Most traditional bio-fuels are unprocessed organic material used in its natural, primary form. The term "solid fuel" is used to include both unprocessed bio-fuels and coal.

[21] One study in India found a 50% adjusted excess risk of stillbirth among women using biomass fuels during pregnancy (cited in Smith, K.R., S. Mehta and M. Maeusezahl-Feuz (2004). 'Indoor Air Pollution From Household Use of Solid Fuels'. In M. Ezzati, A. Lopez, A. Rodgers and C. Murray (eds). Comparative Quantification of Health Risks, Vol 2, WHO: Geneva, p. 1453).

Domestic energy shortages are not confined to the poor households, since in many regions much of the cooking fuel is gathered even among the well-off.[22]

(iii) Culture and gender inequality in health

People or specific groups may face additional health risks due to the specific socio-economic environments that are largely determined by dominant cultural values, which in turn contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services. The cultural environment can strongly constrain the behaviour of men and women through powerful cultural components that closely regulate the lives of men and women through the establishment of powerful social institutions.

Morocco is a case in point. The Moroccan society has strong social norms and role assignments for men and women. Dominant social norms shape the structure and functioning of the society. Control over men's and women's behaviours is ensured through a set of three substantive designata: (i) rituals, (ii) the codes of honour and morality, and (iii) the concept of 'collective self'. These three designata are 'created', 'fostered' and 'perpetuated' in the unit of the Moroccan social organization, the family. The father is the absolute head of the family, and his authority over his wife (or wives) and children is culturally sanctioned. As a result, a gender hierarchy whereby males have authority over females is established at the onset of the basic cell of society: the family.

The family in Morocco is in most cases agnatic and patriarchal, but it is becoming more complex currently. After independence, the country started its process of modernization with the emergence of modern cities and sustained rural exodus to urban areas. Nuclear families-- husband and wife and their unmarried children --are common in urban areas. For the vast majority of women live in sub-urban areas and the countryside, extended households maintain the traditional family hierarchy.

This dramatic transition upset traditional Moroccan social organization and resulted in relatively 'abrupt' gender-related transformations. Two competing sets of paradigms co-exist in most aspects of Maghribi life emerged: one "traditional", the other "modern". On the whole, however, gender relations in the family remain strongly patriarchal and ideologies of male superiority prevail. The family still seeks to exercise tight control over women and their bodies. An unmarried woman is expected to live in the family home, obey her father and conduct herself modestly. After marriage the subordination shifts to the authority of the husband and his family. Female virginity before marriage (or at least the public perception thereof) is considered essential to the maintenance of family honour. Women who choose to live on their own are often the subject of suspicion and sometimes outright hostility.

There is a direct relationship between how culture manifests itself in norms, legal instruments and unequal access to goods and services, opportunities and rights, and these contribute to health (in-)equalities and outcomes. Lack of access to decision-making and

[22] In rural India, 85% of cooking fuel in the mid-1990s was gathered and not purchased.

control of sexuality enforces taboo and results in limited access to health services. The male dominated culture appears to influence on male and female behaviours with regard to reproductive health. For example, in the region, the most popular way of the family planning is to use the pill and other contraceptive methods are not sought. Furthermore, given the fact that the taboo associated with single mothers is still strongly felt in the society, these mothers face high risk deliveries because they are likely to give birth outside the formal health systems. In addition, family planning initiatives by the Government often meets resistance.

V. National Responses to Health Inequalities: addressing the impact of macroeconomic shocks

The provision of health care services for all is a goal shared by the international community.[23] Common to many of developing countries, however, are also challenges related to the adequacy of human and financial resources available and the equitable allocation of such resources among different groups of the population not only in the health sector, but also in other sectors, such as education and economic and social infrastructure. The poor and disadvantaged are most likely to be adversely affected by these shortcomings, despite their greater need.

Many developing countries faced significant reversals in social welfare policies during the 1980s when implementing structural adjustment programmes (SAPs). SAPs consisted of a set of components – balance of payments adjustment, trade liberalization, privatization, monetary discipline and fiscal austerity. The last component, in many cases, led to reductions in public spending on social services and subsidies accompanied by cost recovery measures such as the introduction of user fees (officially charged fees).

Because of the complex relationships between the macroeconomic environment and health outcomes, no outright conclusion on the impact of SAPs on health is possible. The WHO Commission on Macroeconomics and Health,[24] which reviewed 72 articles examining empirical evidence or methodological approaches on the impact of macroeconomic adjustment policies, including SAPs, found both positive and negative consequences on health outcomes. In sub-Saharan Africa, however, it found mostly negative consequences. Largely owing to the lack of data, particularly across different socio-economic groups, the report was short of analyzing the impact of SAPs on health inequalities.

More recently greater availability of health indicators has made it possible to draw a broad consensus. Accordingly, user fees have been found to be a barrier to access to

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[23] WHO (2008), World Health Report 2008, op. cit..

[24] Breman, A. and C. Shelton (2001). "Structural adjustment and health: a literature review of the debate, its role-players and presented empirical evidence", Commission on Macroeconomics and Health (CMH), Working Paper Series, no. WG6:6, World Health Organization.

health services, particularly for the poor, exacerbating health inequalities between the poor and the rich. But user fees appear to be only one of the several barriers that the poor face. Other "direct" costs that have been identified to prevent the poor from accessing health care services including informal fees (including in-kind transactions) and costs of drugs and other health supplies. Other types of indirect costs and non-monetary factors include travel costs, quality of health services the poor receives, inadequate supply of properly trained health workers and the availability of essential drugs on daily basis and the lack of information on the need for appropriate health services. As seen above, in some countries women may face less freedom to decide on medical or health treatment they would like to take.

Several countries, however, have recently introduced health policy initiatives to address these problems, largely within the framework of the two international development initiatives – the MDGs and the PRSPs.[25] One of such attempts is to remove user fees as it was the case of Uganda (see box 3). [Others are the use of "bare foot doctors" to mitigate the shortages of health professionals and the involvement of local communities to advance public health.]

The current global economic crisis, however, threatens progress achieved so far by many developing countries. Any shortfall in fiscal revenues (including grants), due to the economic slowdown, could have large repercussions on health through pressures on health budget. This was well documented in cases of central and eastern European and the Commonwealth of Independent States during the 1990s, where economic difficulties led to reduction of employment in the health sector and the shrinking role of the Government to fiancé health expenditure. As a result, some CIS countries experienced declines in life expectancy at birth and Armenia, Moldova and countries in CIS Central Asia increased incidence of tuberculosis.[26]

The worse-off rely on public assistance on health for receiving essential health services such as primary health care and immunizations. Moreover, falling remittances, increasing unemployment and lower wages imply fewer resources available to cover for health costs, including losing access to health insurance provided through employment. As reported in table 1, a great share of health costs is covered by out of private expense in low income countries. The economic crisis may lead people to pay less attention to health, as it becomes less affordable, particularly preventive care which can have very serious implications in the future. Demand for public health care services will likely increase at a time when these systems are already overly stretched. Countries which depend on foreign assistance for the delivery of basic health care seem to be facing greater risks if ODA flows are not sustained.

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[25] Gwatkin Davidson R. et al. (2005). *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why* (Washington, D. C.: World Bank).

[26] Golinowska, Stanislawa and Agnieszka Sowa (2008). "Inequalities of access to health care services and health status in CEE and CIS countries" (draft), a paper prepared for the Expert Group Meeting on global public health, November.

Public health is also expected to be affected by the implications of rising food prices on nutrition. Since 2006, between 109 and 126 million people are estimated to have fallen below the $1-per-day poverty line due to increased food prices [27] Moreover, recent price declines in food prices alone do not seem to reverse the trends because the current level of food prices is still historically high. In view of the current global crisis, health interventions should be complemented by strengthening the development finance in the agricultural sector to secure resources for food and consequently health for all.

VI. Global Health Partnerships

This section examines the role of international cooperation, with particular emphasis on the GHPs, in advancing public health in developing countries and reducing health inequalities. Global health partnerships (GHPs) have been designed to assist recipient countries to advance public health in general and to achieve the MDGs in particular. The emergence of GHPs has had both positive and negative effects on the capacity of developing countries to make effective advances in tackling health problems. The impact of the GHPs on the international aid framework is examined in detail in the appendix at the end of this paper.

International development assistance on health has accelerated since the launching of the Millennium Development Goals in 2000 and amounted to a total of $12.6 billion worth of commitments in 2006 by both bilateral and multilateral donors of the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC). Disbursements reached $10 billion, on average, in the period 2005-2006 and corresponded to 17 per cent of donors' total disbursements from 9 per cent in 1996-1999. Sub-Saharan African is the largest recipient region of health aid.

There have been significant changes in the pattern of resource allocation within the sector. While HIV/AIDS and infectious disease control absorbed about 20 per cent of the ODA commitments in the 1990s (12 and 8 per cent, respectively), these programmes accounted for 51 per cent of all commitments in 2005-2006 (35 and 16 per cent, respectively). On the other hand, the share of general health (health policy, training and research) declined from 36 to 18 per cent during the period.[28]

The health sector has also witnessed a proliferation of new actors and new institutional arrangements: between 80 and 100 international alliances have been created to attain the international development goals and to enhance the efficiency of aid and its traditional channels of allocation and management. The World Health Organization (WHO) has identified these alliances, called global health partnerships (GHPs), as a key of achieving significant improvements in the field of health on an international scale. According to the WHO, public-private alliances are understood as those partnerships which "bring

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[27] DESA/UN (2008). "Don't forget the food crisis: new policy direction needed", *UN-DESA Policy Brief*, No. 8 (October).

[28] OECD, Measuring aid to health, October 2008; and OECD, Recent trends in official development assistance to health, 2006

together a set of actors for the common goal of improving the health of a population through mutually agreed roles and principles".

Partnerships function acceptably well, especially in terms of overall improved access to treatments, therapies and medicines. At the same time, there are concerns about the role of GHPs in addressing heath inequality, their impact on national health systems and on the coherence of the international aid architecture. Ways in which GHPs operate in recipient countries affect health care deliveries within countries' national health systems and the allocation of health services among socio-economic groups and geographical areas.

A. Scope of GHPs

In terms of the scope of its activity, the GHPs focus on at least one of the following areas and, in many cases, target some of them simultaneously:

i. *Research and development*: dedicating resources to the discovery and development of new treatments, products and vaccines.
ii. *Technical assistance and service support*: directing resources and technical support towards the definition of policies and the improvement of population access to pharmaceutical products and medical services.
iii. *Advocacy*: improving the response capacity (both the national and international response) to specific diseases, promoting the participation and resources to tackle them.
iv. *Financing/funding*: promoting resources for specific programmes.

GHPs that aim at research and development are designed to increase investment and research efforts in new medicines, vaccines or diagnostic tests in relation to diseases which affect the developing world disproportionably. This type of partnership typically involves the pharmaceutical industry as well as philanthropic foundations. The *Global Alliance for TB Drug Development*, which involves Glaxo Smith Kline, among others, and the *Medicines for Malaria Venture*, which brings together Hoffmann La Roche, Basilea Pharmaceutica and Fulcrum Pharma are cases in point. Multilateral organisations are frequent participants of GHPs. As expected, the WHO takes part in most initiatives (43 out of around 80 studied), followed by UNICEF (21) and the World Bank (18).Well-known financing partnerships that have the largest funding and international impact are the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI).

Most GHPs have multiple objectives. They aim at the development of new products and treatments through research and development as well as to increasing access of the poorest population to products and treatments. Additionally, most of them take a disease-specific or condition-specific approach in their health programs. In fact, around 60 per cent of them target three diseases, namely, HIV/AIDS, Tuberculosis and Malaria. However, there are also GHPs devoted to the eradication of diseases which affect a

smaller share of the population and to infections which are less well-known and about which the general public is less aware, such as Dengue, Chagas, guinea worm, and others.[29] Only a small number of GHPs are designed to strengthening national health services.

B. GHPs and the promotion of equality

The objectives of global health partnerships are, among other things, to eradicate specific diseases and mitigate their adverse impact in developing countries as well as to expand actions and resources with the aim of attaining the internationally agreed development goals in health. But GHPs' workings in recipient countries may worsen existing inequalities in health while most GHPs claim to be pro-poor. In fact, there are concerns about whether anti-poverty and gender equality approaches are sufficiently integrated into the GHP practices. DFID (2004) concludes that "GHPs are in practice only as pro-poor or gender-sensitive as the policy environment and health systems they operate within".[30]

In principle, there are four channels through which the relationship between GHP and equality may be considered. Firstly, through the relationship between poverty and diseases and geographical areas where the GHPs operate; secondly, through the selection of beneficiary countries for the GHP; thirdly, through the impact on national health services; and, fourthly, through the working procedures followed by the GHP in the countries where they operate

(i) Tackling the poverty-disease nexus

There are clear inter-linkages among incidence of poverty, other types of inequalities and a large share of the diseases and areas targeted by the GHP. For example, it is recognised that social and gender inequality increases the risk of HIV infection and, once infected, the same inequality acts as a barrier against proper treatment. In this case, then, the action of the GHP on diseases should have a positive effect on the living conditions of the poorest sectors. This conclusion could be generalized to a large part of the diseases that the GHPs target, especially those so called neglected diseases, devastating the most marginalised sectors of society in the developing world. However, this positive effect is limited by the small degree of attention which the GHPs have dedicated to strengthening national health systems (NHSs) and by the unintended adverse impact that they may cause on NHS, as discussed below.

Health specialists recognise that individuals have different capacities of benefiting from health care services, even if they are provided equitably. In addition, the provision of services does not reflect the actual use of those services by different sectors of society. There is ample evidence that improvements in the access to antiretroviral treatments in

[29] Ito, B (2007): "Global Health Partnership and Funding System", en H. Uchimura (Ed), *Health Service and Poverty: Making Health Services more Accessible to the Poor*, Institute of Developing Economies
[30] DFID (2004): *Assessing the Impact of Global Health Partnerships*, DFID Health Resource Centre

Africa, for example, do not necessarily lead to the actual use of those treatments by many people. In order to ensure that provision benefits all, it is necessary to address the social conditions within which people live and work. This means strengthening national structures of primary health care, which aims at providing rational, evidence-based and anticipatory responses to health needs and to the social expectations. By starting with these structures, not only can improvements be made to the socioeconomic factors associated with health, but the treatments can also be adapted to the specific conditions (both social and cultural) of each group. As DAsante and Zwi point out attaining good health, "cannot therefore be effectively promoted through partnerships that focus narrowly on improving drug access; rather, it must to be pursued as part of a broader reform to strengthen health systems".[31]

Additionally, there is no guarantee that the investment in health care is targeted to poor people, even if the attention is dedicated to the diseases that mainly affect poor people. In fact, there is evidence that the rates of use of standard primary health care interventions for immunisation, oral rehydration therapy, medical treatment of diarrhoea and acute respiratory infection and attended deliveries are higher in upper socioeconomic groups than in lower groups[32] The poor requires greater effort to be reached because of their limited resources and ability to use even heavily subsidised health services.

(ii) Allocation of resources: poor countries, diseases of the poor

GHPs can also promote equity by concentrating their attention and resources on the poorest countries. GHP are oriented mainly to fight against infectious disease, 90 per cent of which are reported in developing countries, whereas these countries account for only 12 per cent of global expenditure on health. GHP activity and resources are mainly oriented to poorer geographical areas, especially sub-Saharan countries. For example, 60 per cent of approved funds in Rounds 1-8 of the Global Fund are for sub-Saharan Africa. Eligibility to GAVI funds is restricted to countries with a Gross National Income (GNI) per capita below US$1,000 in 2003.

GHP aid allocation seems to be in correspondence with the purpose to reduce international inequalities. While this is encouraging and can contribute to reduce gaps across countries, it does not guarantee—except in massive campaigns or approaches aiming at reaching a significantly large share of the population—that inequality within a given countries will be reduced and that the most disadvantaged groups will be reached. As highlighted in the appendix, many poor countries need proper technical assistance in order to access fully the benefits of GHPs and here, too, significant shortcomings have been found due to the limited attention which GHPs have given to support activities and technical assistance in beneficiary countries. The GHPs' limited attention to technical support has made it difficult for the poorest countries to maximize benefits from the GHPs' programmes.

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[31] DAsante, A. and A. Zwi (2007): "Public-private partnerships and global health equity: prospects and challenges", *Indian Journal of Medical Ethics*, Oct-Dec

[32] Gwatkin, Davidson R. *et al.* (eds.) (2005). *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What doesn't and Why*. Washington, D.C.: World Bank.

More importantly, however, is whether these initiatives are addressing diseases that affect the poor and other disadvantaged groups in particular. In spite of the important achievements accomplished in HIV/AIDS, it should be recalled that today the top killer diseases in most poor countries are respiratory and intestinal diseases leading children to death from pulmonary failure or diarrhoea (see table 6). But there is very little advocacy for addressing these problems and there is no GHP to support them.

In some countries, very large GHPs emphasizing a single disease (such as is the case of those focusing on HIV/AIDS) may unintentionally be addressing the needs of small groups to the detriment of the majority. For instance, the World Bank reports that in Mozambique the epidemic and endemic risks for malaria are high (21 and 57 per cent respectively), while child mortality is also high at 118 per 1000 live births. Meanwhile, AIDS prevalence rate reaches 3 per cent but funds allocated for the disease is 2.5 times larger than for malaria and 46 times that for integrated management of childhood diseases. In Uganda, the very rapid increase in allocations to address HIV/AIDS has pulled medical personnel from other parts of the health sector compromising delivery of services.[33]

(iii) Impact on national health services

GHPs have often channelled resources to support a particular disease programme. This vertical approach, however, not necessarily complements but often competes with the approaches that seek to tackle the overall health problems on a wider front (horizontal approaches). The effective and equitable of the diseases targeted by the GHPs depends on the ability of the national health systems to integrate preventative, diagnostic and therapeutic measures in the sphere of primary health care, which is frequently inadequate in low income countries.

In fact, problems often arise in the limited attention which the GHPs place on strengthening the national health systems and in the impact these funds can have on the capacities, both in terms of human and technical resources, of the national systems. This has important implications for the provision of primary health care and thus health interventions for the poor and the neglected groups. While some GHPs have committed resources to strengthen local, these resources are often earmarked to services and institutions related to a specific disease to which the GHP is targeted.[34] From an operational perspective, a government may receive funds from the GHPs to support a specific programme, but may have limited financial capacity to deliver basic health care outside the scope of the GHPs.

In other instances, GHPs have affected national health services and the supply of basic health care services by attracting health professionals away from the public sector—

[33] World Bank (The Global Programs and Partnership Group. Concessional Finance and Global Patnerships Vice Presidency) Global Funds at the Country Level: What Have We Learned? (July 2008)
[34] See for instance, The Global Fund, Fact Sheet: The Global Fund's approach to health system strengthening, Global Fund Fact Sheet series, 5 of 5, 1 March 2008.

which already facing considerable shortages of skills—to higher paid positions within the GHPs. Furthermore, the vertical nature of their approach creates a new type of front-line healthcare workers with very specific skills, which may not correspond to the overall needs of the country. In general, people living in remote areas, urban slums or particular geographical areas with high concentration of ethnic minorities heavily depend on such basic, primary care services. As observed elsewhere, "there is a serious risk that weak human resource and systems capacity at central and local levels can be overwhelmed by the growing proliferation of GHP –and other HIV/AIDS initiatives- with separate demands".[35]

(iv) Adjusting working procedures

It is not possible to make progress on health equity if this objective is not explicitly incorporated into the definition and design of the interventions. Some GHPs, however, seem to take into account consideration to inequality. The United States President's Emergency Plan for AIDs Relief (PEPFAR), for instance, indicated that it increased the share of children receiving PEPFAR-supported treatment in total beneficiaries from 3 percent in fiscal year (FY) 2004 to 8 percent in FY2008. It also plans, through FY2013, to work with host nations to support care for 12 million people, 40 per cent of which are orphans and vulnerable children.[36] PEPFAR acknowledges inequalities between genders which "perpetuate women's vulnerability to HIV[37] and seems to have a special focus on women as 61 per cent of those receiving antiretroviral treatment are women (it is important to keep in mind that HIV/AIDS prevalence is higher among women than man in targeted countries). The Global Fund guidelines, in turn, are reported to encourage countries to consider social and gender inequalities in their applications.[38] Yet, it is not clear whether or not this recommendation has been followed in all cases and how such considerations address existing inequities.

At the same time, the use of generalized procedures *"one size fits all"* by the GHPs with no particular consideration to the institutional and cultural environment which affect diverse communities has not helped develop grass root approaches which are sensitive to the conditions of the poorest. As Hanefeld (2008) points out, "GHIs [global health initiatives] need to consider social inequities, including gender inequities, in designing context-specific programmes, to ensure that these are equally accessible to women and men".[39]

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[35] DFID (2004): *Assessing the Impact of Global Health Partnerships*, DFID Health Resource Centre.
[36] Celebrating Life: Latest PEPFAR Results (http://www.pepfar.gov/documents/organization/115411.pdf)
[37] Chapter 4: Gender and HIV/AIDS -- Responding to Critical Issues The President's Emergency Plan for AIDS Relief: Second Annual Report to Congress (2006). Available at http://www.state.gov/s/gac/rl/61286.htm
[38] Johanna Hanefeld and others. How have global health initiatives impacted on health equity? What strategies can be out in place to enhance their positive impact and mitigate negative impacts? A literature review commissioned by the Health Systems Knowledge NetWork (January 2007).
[39] Hanefeld, J. (2008): "How have Global Health Initiatives impacted on health equity?" *Promotion and Education* 15.

Moreover, there are inconsistencies in the GHPs that affect their potential contribution to address equity issues effectively. For instance,the participation of pharmaceutical companies may have negative implications for equity. These companies have sometimes tried to limit the ability of developing countries to use the flexibilities allowed in TRIPS and to improve the access of their populations to essential medicines through the supply of generic products or by overriding patent rights. In fact, some partnerships may insist on the use of specific drugs bypassing the less expensive generic alternatives. PEPFAR is a case in point. Additionally, although national governments participate in the partnerships, objectives need to be clearly established and shared among stakeholders, so as to prevent public funds from being used to benefit the companies involved, instead of improving health outcomes of a given population.

Without strong links to poverty reduction processes (and adherence to the Paris principles of aid effectiveness), scaling up aid may not have as strong positive impacts on health equality. GHPs are no exception. In particular, GHPs should be more explicitly linked to the Poverty Reduction Strategy Papers (PRSPs) while the latter should also take into account the need to create additional "fiscal space" for health – i.e., space in the public budget to scale up health. In case of Rwanda, for example, where the Government is accountable for delivering the goals in its PRSP, much of the assistance in the health sector was channelled through GHPs and other vertical programmes. Only 14 per cent of aid for health the Government received passed through fiscal budget. The difficulty for the Government is that if it misses the PRSP goals, it may face aid suspension and other negative reactions from donors even though it does not exercise much control over the financial resources received. Additionally, macroeconomic stability still dominates PRSPs' concerns, which constrains expenditures increases in health.

VI. Conclusions and Recommendations

Inequality matters for achieving goals of global public health: numerical targets can be mechanically met while many are left behind thus affecting overall health achievement. The less privileged members of society can be often bypassed.

The health status of a given population is the result of the complex interaction of a wide range of factors which go beyond the jurisdiction of health authorities. Addressing health challenges requires a comprehensive approach by policy makers. Improving health outcomes in a sustained and equitable manner goes beyond the simple provision of treatments and medicines. It demands corrective action to be taken on the social factors which determine people's health conditions, as emphasized in the WHO report on the social determinants of health.

In this regard, while health needs to be mainstreamed into overall development strategies, it is also necessary to integrate social and gender considerations and to address existing inequities in making health care available and accessed by those who need it. It is necessary to strengthen national health systems by improving the quality and increasing the supply of primary care, thus making health services available to all. Accordingly,

health-related policies and other interventions at the national and international levels need to be introduced to reduce inequalities in health. These include:

(i) Adjusting the aggregate health goals to reflect the need to address existing inequalities. The aggregate health goal for each country should be adjusted to include explicit health goals in terms of health outcomes for the poor and other neglected groups, so as to advance the promotion of health for all.[40] Each country should adopt specific performance targets for the poor or the disadvantaged in allocation of funds to hospitals and health centres which are located in the neglected areas. It should be noted that the poor benefit more from the supply of primary health care than from care extended by hospitals and/or made available through expensive treatments.

(ii) Introducing inequality impact assessment for interventions in the health sector. This measure would draw attention to the inequality implications of proposed actions by local authorities and by the international cooperation. An indicator on health inequality can be added to the Millennium Development Goals, so that the international community seeks to monitor impacts of health interventions on the distribution of health. The responsibility of improving health of the population and reducing inequalities, however, lies primarily with national governments.

(iii) Removing user charges for public health facilities should contribute to lower barriers to access for the poor. As examined previously, however, this is only the first step. Providing financial support to cover other costs (such as transport and related opportunity costs) of using health services is also necessary. Cash transfer to households who attend health centres/clinics or health education or programmes at school appears to benefit the poor.[41] At the same time, health authorities need to ensure the adequate, uninterrupted supply of drugs and other health items and, most importantly, health care workers. As seen in the case of Uganda in box 3, foreign assistance may be required at least at the beginning of the programme to kick start the national efforts.

(iv)A comprehensive approach is necessary. The international community, including the traditional official donors as well as non-traditional donors have an important role to play in assisting developing countries in improving the health status of their populations. While vertical approaches are useful and have a role to play in the supply of health care, the effectiveness of interventions by GHPs need to be improved. It is necessary to go beyond having a disease-specific focus and to ensure that the causes of social and gender inequities that determine access to health are accurately addressed. Furthermore, GHPs should include measures sensitive to social and gender inequities when establishing their won operational targets. It is essential to ensure that the access to health services does not become less equitable as a result of GHP interventions.

As mentioned above, the best approach requires that recipient and donor governments keep an integral view of the health system, giving priority to primary attention and the

[40] Gwatkin, Davidson R. (2004). "Making health systems more equitable", *Lancet*. vol. 364 (2 October), pp. 1273-1280.
[41] Mexico's Progesa programme is a well known case. See Gwatkin (2004).

strengthening the institutional and technical capacities of the system. GHP should adapt to that logic, mainly local, taking care their action does not weakens (or fragment) the national health system.

(v) Improved coordination is needed while the proliferation of GHPs should be controlled. At the operational level, there are four areas of improvement that should be taken into account by the GHPs: (i) they need to adopt the principles of the Paris Declaration (especially the ones related to alignment and coordination); (ii) there should be a greater effort in subordinating GHPs' action to the recipient country's health system, preserving the leadership of domestic governments in addressing health issues at the local level; (iii) they should review their structures of governance, and (iv) GHPs need to dedicate greater efforts to technical assistance tasks, as a mean to correct the existing inequalities of countries and improve the efficiency of their own programmes.

At the same time, the creation of new GHPs should be restricted in order to avoid the further proliferation of uncoordinated actors within the international aid system and to channel the new proposals and resources through the already existing multilateral institutions. Even if vertical Funds invest resources on strengthening national capacities or improving their harmonization and alignment, difficulties will persist because each initiative has its own governance structures and decision process. Therefore, the problem is not the existence of some vertical funds, but the proliferation of these funds, the overlapping of their mandates and goals, and in certain cases the lack of justification (in terms of inter-temporal optimisation) of its existence.

(vi) Traditional donors should review their criteria of resource allocation. Turning to bilateral official development assistance delivered in the "traditional way", donor countries should decide how to assign their funds and efforts, while keeping in mind that it is necessary to correct the negative impacts created by the rise of GHP over the last several years. It would be important that donors review their criteria of resource allocation to guarantee that recipient countries are able to include GHP efforts in a coordinated way with their own actions in the field of health so that GHP interventions can respond to the specific characteristics of domestic health systems and their respective needs. In some cases, this could mean the review of the contributions donor countries give to GHP in the benefit of a greater support of recipient countries' budgets, thus reinforcing sector wide approaches (SWAPs) and/or the poverty reduction strategies.

(vii) The availability and the quality of the existing data on health indicators need to be improved. The provision of credible and comparable health information should strengthen the commitment and resolution to scale up efforts on public health at the global and national levels. Action against social inequity in general and health inequality in particular will be more effective if the systems, including vital registration and regular monitoring on health outcomes and inequality are in place.

At the same time, reporting inequalities for the sake of reporting is not efficient. Collecting a jigsaw of evidence without a clear policy objective can lead to wrong decisions. Too many indicators are being proposed and, in some cases, data are being

collected without any relation to a policy objective or target and without systematic and scientific sampling methodology. Insufficient guidance is given to countries on data collection and methodology. In this regard, there is a need to:

measure a smaller number of indicators, specifically those with direct relevance to decision-making and high-priority health issues

use more efficient sampling frames and procedures that also enable estimates by different socio-economic groups, and;

develop and apply standard, internationally accepted definitions.

The inter-agency activities on the MDGs could be a good basis to providing guidance and building database on indicators on health inequalities. Strengthening statistical capacity in low income countries will need a concerted effort from governments, from donors, and from multilateral institutions.

Box 1: Spousal violence: a serious health concern

One of the most hidden, pernicious, yet widely prevalent health risks women face globally stems from violence within the home from spouses and other intimate partners. Although still underreported, estimates show that world-wide 10 to 50 per cent of ever-married women, cutting across countries and economic groups, face physical violence from husbands.[42] Marital violence is found to devastate the women who suffer it, scar the children who witness it, and dehumanize the men who perpetrate it. It adversely affects not only individuals but their families, future generations and entire societies. Indeed, the World Health Organization has identified marital violence as a major health concern.[43]

Marital violence is found to cause serious physical and mental injury to women Violence during pregnancy is linked to miscarriages, low birth weight infants, maternal morbidity, and even foetal and maternal deaths.[44] The term 'battered woman syndrome' describes a situation where a woman's sense of self is so damaged that she believes she deserves to be abused.

Physical or mental injury can adversely affect a woman's job prospects, productivity, work regularity, and upward mobility. Even the fear of injury can undermine a woman's ability to earn a living, by making her fearful of reprisal if she goes to work, or to upgrade her skills, or to explore job options. A woman's inability to obtain or hold a job due to marital violence reduces her income. This can reduce not only for own health care prospects but also her children's, given that mothers' incomes tend to benefit child nutrition and healthcare more than father's incomes.[45] Moreover, it erodes her social relationships by keeping away neighbours and friends and by making her withdraw from social contact. Accordingly, it reduces women's ability to seek help during ill-health or pregnancy, and can even affect their life expectancy.

Marital violence also carries direct intergenerational costs, such as foetus damage and psychological damage to children witnessing violence. Such children tend to have higher emotional and behavioural problems than other children and carryover effects into

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[42] Population Reports (1999). Ending violence against women, Issues in World Health, 27(4):1-43.
[43] World Health Organization (WHO). 2000. Women's Mental Health: An Evidence Based Review. Geneva: WHO and WHO (2002). World Report on Violence and Health. Geneva: WHO.
[44] Dannenberg, A.L. Carter, D.M., Lawson, H.W., Ashton, D.M., Dorfman, S.F., & Graham, E.H. (1995). Homicide and other injuries as causes of maternal death in New York City, 1987 through 1991. American Journal of Obstetrics and Gynecology, *172*, 1557-1564, and; Jejeebhoy, S.J. (1998a). Associations between wife-beating and fetal and infant deaths: Impressions from a survey in rural India. *Studies in Family Planning*, *29* (3), 300-308.

[45] Thomas, D., 1990. 'Intra-household Resource Allocation: An Inferential Approach'. Journal of Human Resources, 25 (4): 635-63.

adulthood.[46] Seeing their fathers beat their mothers, girls in adulthood are more likely to accept a husband's abuse and boys are more likely to beat their wives. Marital violence thus undermines the physical and mental capabilities of all family members.

Policies require a multi-pronged approach, including stringent protective laws; promoting legal awareness; sensitizing the legal machinery and police force for effective implementation; safe short-stay homes for women and children; social security systems as economic cushions that battered women can draw upon; preferential job options for the long term; and most importantly subsidized housing, given recent research that women who own or have access to secure alternative housing or land of their own are at substantially lower risk from spousal violence than property-less women.[47]

[46] Edleson, J.L. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14* (8), 839-870, and; McCloskey, L.A., Figueredo, A. J., & Koss, M.P. (1995). The effects of systemic family violence on children's mental health. Child Development, 66,1239-1261.

[47] Agarwal, B. and P. Panda. 2007. 'Toward Freedom from Domestic Violence', Journal of Human Development, 8(3): 359-388

Box 2: Women's health and the environment: in-door air pollution

Half the population of the developing world - about 2.4 billion households - still depend on conventional bio fuels for cooking and heating. These traditional bio fuels – in particular firewood, charcoal, cattle dung and crop waste - are used by over 90% of rural households in sub-Saharan Africa, 80-90% in India, and 50-70% in China and the numbers relying on such fuels is projected to increase to 2.6 million by 2030 (see table below), with the highest numbers and percentages living in Africa and South Asia. Although this reliance is greatest among the poorest households, many well-off households also use traditional bio fuels in substantial extent, even as they move to modern fuels for additional energy needs.[48]

Number of people using traditional biomass for cooking and heating (millions)

Region	Actual	projections	
	2002	2015	2030
Africa	646	805	996
South Asia	746	844	883
India	595	665	693
East Asia (excl. China)	221	211	188
China	704	618	505
Latin America	79	68	60
Developing countries	**2398**	**2549**	**2634**

Source: IEA (2004). World Energy Outlook.

Exposure from cooking with traditional bio fuels using inefficient stoves in poorly ventilated conditions is found to have serious health ill-effects. The smoke produced during the combustion of traditional bio fuels contains pollutants such as particulates, carbon monoxide, nitrogen and sulphur oxide, formaldehyde, and benzopyrene. In Africa and South Asia, 70-80% of the population is exposed to such smoke from the fuels they use domestically. Indoor smoke from solid fuels (unprocessed biofuels plus coal) is globally responsible for 35.7% of lower respiratory infections, 22.0% of chronic obstructive pulmonary disease (COPD) and 2.5% of trachea, bronchus and lung cancer.[49] It is also linked with a higher incidence of tuberculosis, cataracts and asthma. The WHO notes that indoor air pollution is responsible for 2.7% of the global burden of disease.[50] An estimated 1.6 million deaths per year in developing countries are associated with

[48] In an analysis of 2366 rural households in Pakistan, even the richest quintile of households used wood and dung in substantial degree. See Chaudhuri, S. and A. Pfaff (1998). 'Does Indoor Air Quality Fall or Rise as Household Incomes Increase?' Working paper No 1, School of International and Public Affairs, Columbia University.

[49] WHO (2002). World Health Report, World Health Organization, Geneva, p. 70.

[50] WHO (2005). 'Indoor Air Pollution and Health', Fact sheet No. 292. WHO, Geneva.

inhaling smoke from indoor cooking from such fuels, making indoor air pollution the fourth leading cause of premature deaths in developing countries.[51]

Those at greatest risk from these diseases are women who do most of the cooking, and young children playing near or in their mother's laps or carried on their backs. Children are even more at risk directly. WHO estimates that ARI accounts for 20% of child deaths each year (2.2 million out of 11 million).[52] Of these a very large percentage are due to cooking fuel related indoor air pollution. In India alone almost two-thirds of the children under 36 months live in households using only unprocessed biomass fuels for cooking and an estimated 200,000-300,000 Indian children died due to ALRI mortality linked with biomass fuels in 2001.[53] Children being carried on the mother's backs while she is cooking (as is common in rural Africa) are often at greatest risk and this can have gender implications according which gender tends to be carried more. Similarly, in South Asia, girls inducted at a very early age to help mothers cook are at higher risk than boys who are sent out to play.

The provisioning of clean, adequate and affordable domestic energy thus needs priority attention by governments. The solutions will need to be not only technical but also financial and institutional in nature. Improved stoves with chimneys and greater fuel efficiency can also help. Policies in these directions can, however, complement but not substitute for cleaner fuels. A shift to cleaner fuels is possible in the short and medium term, and at a fairly low cost, even with known technologies. A case in point is biogas plants which produce methane gas by anaerobic fermentation of biomass.

Short and long term solutions will require not just adaptation of technology to local needs and appropriate pricing and credit support policies, but also additional institutional inputs. In particular, it will need more participatory and collective approaches for ensuring community involvement, and especially women's participation, in the process of adapting and adopting the cleaner fuels and associated technologies.

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[51] Modi, V., S. McDade, D. Lallement, J. Saghir (2005). Energy Services for the Millennium Development Goals. Washington DC: World Bank, and New York: World Bank.

[52] WHO (2002), op. cit.

[53] Mishra, V., K.R. Smith, R.D. Retherford (2005). 'Effects of Cooking Smoke and Environmental Tobacco Smoke on Acute Respiratory Infections in Young Indian Children', Population and Environment

Box 3: Abolition of user fees in Uganda

Uganda emerged from two decades of upheaval at the end of the 1980s, with an under-quipped and under-staffed health care system.[54] Cost sharing – i.e. user fees – was introduced in public facilities to cover salaries to health workers, alleviate drug shortages and strengthen community management of facilities. User fees and managed revenues were determined at the local level, but often were in the range of US$ 0.25 – 0.45 per visit.[55] After the introduction of the user fees, outpatient attendance dropped by more than 20 per cent in some districts, while the opposite happened in some remote areas. For health employees and community-level health facilities, revenues from user fees became a relatively secure source of income, also allowing for paying for medical and other supplies.

In March 2001, user fees were abolished as there was some evidence that user fees were leading to unnecessary suffering and even death. The major objective of this policy change was to improve access to health services for the poor. The Ministry of Health of the country introduced a supplement fund of US$5.5 million to buffer the loss of revenue and to counter a potential shortage of drugs. The fund was financed by the World Bank-sponsored district health services project.

As a result, there was a significant increase in utilization rates. In public referral facilities – heads of the sub-district health care systems --, utilization rates increased by 26 per cent in 2001 and 55 per cent in 2002. The equivalent rates in public centres (lower level facilities than the referral) were 44 and 77 per cent, respectively.[56] When examining outpatient utilization at health centres among different wealth groups, the poorest (defined as a group of households below the bottom quartile in a wealth-ranking) recorded the highest rate at 0.8 in 2001 and almost 1.0 in 2002, meaning that poor people in the area visited health centres once a year on average.[57] The other groups reached around 0.6 in 2001 and between 0.8 and 0.9 in 2002 showing that the abolition of fees induced other groups also benefited from the measure. Females consistently utilized health facilities more than males before and after the abolition of user fees in 2001 and there is no evidence of a change in this pattern after the elimination of the fees.[58]

Moreover, the abolition of user fees did not seem to have implied deterioration in the quality of services rendered—one of the commonly evoked reasons in support of user fees. For example, there is no significant increase in average stock-out days -- days when a health centre is out of stock of drugs -- per month after the abolition; average drug stock-out appeared to increase in 2001 immediately after the abolition but it declined in

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[54] The case reported here is based on Burnham, Gilbert M et al. (2004). "Discontinuation of cost sharing in Uganda", *Bulletin of the World Health Organization*, vol. 82, No. 3 (March), pp. 187 – 195.

[55] It should be noted that at the beginning of the present century, a little less than 50 per cent of the population earned less than US$1 a day, and 60 per cent US$50 per month.

[56] Nabyonga, J. et al. (2005). "Abolition of cost-sharing in pro-poor: evidence from Uganda", *Health Policy and Planning*, vol. 20, No. 2, pp. 100 – 108.

[57] Outpatient utilization rate is calculated as the ratio between the total number of visits in all health centres in the region and the number of people living in the region.

[58] Utilization rates by wealth group is not reported in the paper.

2002. Other quality aspects of health services, such as staff attitude and availability and health unit cleanliness and maintenance reported no deterioration.

The debate on whether to abolish user fees is pro-poor will continue. For countries like Uganda where the significant portion of the population is poor, the imposition of user fees, however small, makes even basic health care services out of reach.

Appendix

Assessing Global Health Partnerships

The proliferation of GHPs has had both positive and negative effects on the capacity of developing countries in tackling heath problems. One of the most visible contributions of the GHPs has been the integration of agents and resources from various spheres (public and private) into a common and discrete goal. The GHPs thus set a framework within which different perspectives come together to establish formulas for consensus based on the experience and knowledge of all participants. On the negative side, the partnerships have imposed a toll on the coherence of the overall international aid system.

I. Positive aspects

The positive contribution of GHPs to advance health goals can be expressed in terms of:

Operative efficiency

The GHP have functioned acceptably well, especially in terms of improved access to treatments, therapies and medicines. For instance, by December 2008, the Global Fund had provided AIDS treatment for 2 million people, TB treatment for 4.6 million people under Directly-Observed Treatment, Short-course (DOTS), distributed 70 million insecticide-treated bed nets (ITNs) to protect families from malaria. These initiatives are estimated to have contributed to save the lives of some 2.5 million people. GHPs have stimulated the research and development of new markets and new products and helped to reduce the production costs and risks associated with new product development. Due to increased demand, additional markets have been secured for the eventual products coming from innovation and research efforts.[59] At the same time, a significant reduction in the price of some pharmaceutical products has been achieved in developing countries. For example, HIV treatment in the poorest countries now cost close to a tenth of that in developed countries.

Additionally, there are indications that the GHPs have promoted better policies for the treatment of the diseases concerned in the beneficiary countries by giving national systems better means of planning their goals and determining their future needs. Improvements have also been noticed in monitoring practices, transparency in procedures and, even, in some cases, the participation of many agents, including NGOs, in defining health policies. Nevertheless, these results co exist, in some cases, with inefficiencies in access to less costly medicines such as generic drugs, delays in the release of payments, and in the implementation of programmes or even the limited capacity of funds to impact on certain types of diseases..

Increased resource mobilization

[59] Global Fund to Fight AIDS, Tuberculosis and Malaria at http://www.theglobalfund.org/en/partnership/?lang=en (accessed on 3 February 2009).

The emergence of GHPs has led to a significant mobilization of efforts and resources to tackle goals in the field of health. This increased capacity to mobilise funds is largely owing to the fact that this type of framework, private agents – such as foundations and companies – found a suitable means of joining these initiatives. Yet, the availability of resources is still below what is needed to achieve the MDGs in health.

It is important to notice, however, that official donors have frequently redirected a part of their international aid in health to new activities related to supporting GHPs. For instance, during the period 2001-2008, official bilateral donors provided $1.5 billion to GAVI, which corresponds to 40 per cent of all resources donated to that partnership. Additionally $1.2 billion have been raised through the international financial facility for immunizations (IFFIm), a financing mechanism that aim at accelerating the availability and predictability of funds for immunisation used in GAVI. Official bilateral donors also take part in the financing of Global Fund and contributed with over $8 billion—or 80 per cent of total funds contributed—over the period 2001-2007. Thus, only part of the resources mobilized by the GHPs is actual new money for health.

II. Risks and inefficiencies

The proliferation of GHPs is not without problems and risks. Most of those risks come from the effect that GHPs have on national health systems (discussed in the main text of this chapter), on one hand, and on the coherence and efficiency of the international framework for cooperation for development, on the other.

The sustainability of interventions, resource predictability and effects on financial stability

The way in which GHPs operate can have undesirable effects on the recipient countries' ability to manage their budgets. The problems are diverse. First, there may be problems regarding *absorption* of the funds and initiatives in the recipient countries, especially when national administrations—often facing severe technical and institutional constraints—have to be involved in management of such funds and programmes. Second, the limited *predictability* of activities and funds to be released is a cause of concerns. The fact that part of the funding is sometimes made outside the budget and with the participation of other agents outside the public system (such as NGOs) only compounds the problem. The dynamics of decision making and resource management is thus superimposed on the budgetary cycle of the recipient country, making it difficult to properly integrate these resources into the country's budgetary processes. Third, *financial stability* can be compromised as, in some cases, the sums involved amount to an injection of resources large enough to affect macroeconomic stability. A fourth problem refers to the *sustainability* of interventions, since the GHPs increase the level of operations far above the administrative capacity of the government.

With respect to aid predictability, there is increasing concern at present about the implications of the current economic crisis for heath outcomes in recipient countries. Past economic crises such as those in Norway and Sweden in the early 1990s have shown declines in aid in the subsequent years with their eventual return. In case of Finland and

Japan, which also faced economic crises in the 1990s, their aid flows have not yet returned to their peak values. A decrease in aid for these already poor countries would have devastating effects on the progresses that have already been made in matters of immunization and access to treatment and care against deadly infectious diseases if partnerships are forced to lower their support for these countries.

System coherence and transaction costs

Another type of risks associated with the proliferation of the GHPs refers to their impact on the functioning of the entire international aid architecture, on one hand, and on the effectiveness of the interventions, on the other. Due to the support granted by the new agents involved in the global initiatives, the social sectors have absorbed a larger share aid, to the detriment of the productive sectors. However, these latter sectors are crucial for development, not only because the living conditions of the poor depend on them, but also because they constitute the basis on which the achievements made in social issues (including those related to health) can be made sustainable.

The proliferation of vertical initiatives, when uncoordinated, creates a serious problem in terms of harmonization among donors and the alignment of those with the priorities and procedures of the recipient country. There is a need to clearly define roles and responsibilities of the partners to avoid duplication among the different programs, as well as minimize possible competition between the different programs. One recurrent problem is the lack of country presence of some partners, who operate with little administrative staff or do not have in-country workers altogether, complicating communication and coordination efforts.

Additionally, a high burden is placed on the recipient's national administration as it deals with numerous agents with diversified procedures, demands and work dynamics. The problem is exacerbated if GHPs' vertical nature is taken into account, that is, their highly specialised areas of action –*issue-specific*- aiming to accomplish immediate results -*quick-results oriented.* However, this approach has meant that the partnerships have tended to consider each activity (disease or task) as issue-specific, with its own international response, thereby giving up a more global or wide-ranging vision of the components of health.

Integration of the GHP in the Sector-Wide Approach (see box A.1), which strictly adheres to working application of the Paris Declaration, could correct some of these shortcomings. The principles of the Declaration are entirely pertinent to GHPs, but it has to be said that the degree to which those principles have been implemented by these funds is very low (see box A.2). Neither one of these alternatives is generalized practice among GHPs.

Necessity to combine resources and technical assistance

Many studies point out that GHPs do not have adequate technical support component in their programmes that aim at helping the recipient countries access the funds, adequately

absorb resources and manage health interventions or aid programmes. Recipient countries, especially the poorest ones, have limited capacity to judge which of the many available funds is the most appropriate for their needs or which programmes they can participate with certain possibilities of success.

Technical assistance is necessary to allow recipient countries to fully benefits from a GHP. Assistance is especially relevant in the areas of planning, budgeting, monitoring and evaluation, in training and in the implementation of the initiatives. Although there are initiatives to finance technical assistance within the GHP framework, the majority of them are ad hoc proposals, granted on request.

Systems of governance

GHPs also suffer from governance issues. Some GHPs have their own, independent, legal framework (like *GFATM,* for example), while others are hosted by another institution (for instance the WHO as is the case of GAVI, Global Partnership, Stop TB and Roll Back Malaria). Independent institutions carry higher operating costs. Meanwhile, in case hosted a GHPs and its host may face coordination issues with regard to the governing structures and operating procedures of both the host and the hosted. It is difficult for a *partnership* to take place if the roles and responsibility of the agents involved are not agreed and properly aligned.

Issues of representation in the GHPs arise when one partner overly dominates the other partners, when some partners have only limited presence (as with the NGO) or when the developing countries are not adequately represented.[60] Problems of accountability for the GHPs may also arise not only with their partners, but also with beneficiaries and with public opinion in general. In fact, recipient countries feel that decisions come from the top to the bottom in a large part of the GHPs and that there is limited transparency in the decision processes. As DAsante and Zwi (2007) point out, referring to the operative procedures of the GHPs, "the process of selecting private partners, the setting of targets to be achieved and the formulation of management guidelines are anything but transparent."[61]

[60] For instance, as Buse and Harmer (2007) stated, the representation of low and medium income countries barely reached 17% in the governing structures of a wide section of GHPs; and NGO hardly reach 5% (while companies reach 23%).

[61] DAsante, A. and A. Zwi (2007): "Public-private partnerships and global health equity: prospects and challenges", *Indian Journal of Medical Ethics*, Oct-Dec.

Box A.1: SWAp: Sector-Wide Approach

The Sector Wide Approach (SWAp) initiative emerged from the Sector Investment Programme (SIP), a concept promoted by the World Bank in the mid-1990s and now utilized by bilateral and UN agencies. [62] The SWAp has the purpose of "fostering ownership, improve donor harmonization and aid predictability and align policy behind a health-reform program agreed between government and donors".[63] The approach has contributed to increasing health sector coordination, enhancing national leadership and ownership and strengthened management in the countries as well as the delivery systems.

The approach implies that the ministry of health takes leadership in the coordination of aid and the direction of the activities. Donors are also to be responsible for synchronizing their planning, review and monitoring systems with that of the government, as well as providing long-term projections of their contributions.[64]

The SWAp programme requires consensus among stakeholder in the direction of the health system strategy, as well as the responsibility of the partners to carefully monitor the implementation of the programs. The World Bank particpates in approximately 30 health-related SWAps in 20 countries.

The main constraints to the implementation of a SWAp are limited capacity of the health ministry to direct the programmes due to lack of experience, poor relationship with the other sectors and slow shift of ownership to the ministry. Furthermore, the donors may not adequately take into account the national development framework and the national particularities when implementing their programs or setting their targets. Additionally, implementing a SWAp depends on the concrete agreement on a single strategy among all of the partners that includes the government, funding agencies and other stakeholders. If these conditions are not in place, then the SWAp is likely to not be successful. If they are, it can improve the health of the population in the country, while strengthening the national health system.

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[62] Larsen, Bjarne (2003). "Sector wide approach - history and some theoretical considerations", paper presented for Chief Advisors at Danida Seminar (June).

[63] Working Party on Aid Effectiveness and Donor Practice, World Health Organization, World Bank and the OECD/DAC (2007). Proposal to use health as a "Tracer sector" for tracking progress on the Paris Declaration.

[64] Hutton, G. and M. Tanner (2004). "The sector-wide approach: a blessing for public health?" *Bulletin of the World Health Organization.*

Box A.2: The Paris Declaration and global health partnerships

The relevance of the principles of the Declaration of Paris in the field of health is high:

O*wnership* should be applied to the health system, at least on two accounts. First, plans on health matters should be ensured to be created and developed from national foundations. The GHPs, like other donors, should integrate themselves into those plans and strengthen their design and development. Second, health ministries should engage in framing "upstream" development strategies, improving the budgetary conditions in which the sector operates.

Health aid should be *aligned* with national systems, including systems which provide health services; those related to information, monitoring and evaluation of public policies; and the national procurement systems. In this regard, it is necessary to operate through a multi annual plan so as to allow for increased predictability of resources and for the country to develop its institutional capability.

The *harmonisation* and simplification of procedures of the GHPs is needed to reduce operation costs because many different kinds of agents are at presence in the heath sector (bilateral and multilateral, public and private), and their activities are very diverse (different diseases, research, treatment, strengthening of institutions and etc. Harmonisation is also a prerequisite for encouraging a better coordination between agents.

It is necessary to *manage the programme by* results. This requires reaching a consensus among stakeholders on the procedures for monitoring and evaluating interventions. For this to happen, improved information systems in the health field should be installed because many poor countries are not yet adequately equipped with.

Finally, it is necessary to implement systems of *mutual accountability* between donors and recipients. This means the GHPs must adopt more flexible stances and maintain open dialogue with national authorities and improve their systems of governance in health.

Tables

Table 1: Health disparities between developing and developed countries

Country groups by income level	Life expectancy at birth in years (2006)	Under 5 mortality Rate per 1,000 live birth (2006)	Total expenditure on health as % of GDP (2005)	Private expenditure on health as % of total expenditure on health (2005)
Low-income	59	110	4.6	74.1
Lower-middle income	71	35	4.8	55.1
Middle- income	69	26	6.6	46.8
High-income	80	7	11.2	39.9
World	65	71	8.6	44

Source: UN/DESA, based on WHO, World Health Statistics 2008.

Table 2: Distribution of ratio of under 5 mortality rate between two different socio-economic groups in developing countries (number of countries)

ratio	Lowest and highest wealth quintile	Lowest and highest education of Mother
1 - 2	26	23
2 - 3	15	33
3 - 4	12	5
4 +	2	0

Source: WHO, World Health Statistics 2008.

Table 3: Life expectancy and healthy life expectancy at birth (years)						
Income group	Life expectancy (2006)			Health life expectancy (2002)		
	Male	Female	Difference	Male	Female	Difference
Low income	58	60	2	50	50	0
Lower middle income	69	73	4	60	63	3
Upper middle income	66	73	7	60	66	6
High income	77	82	5	69	73	4

Source: World Health Statistics, 2008.

Table 4. Set ratio at birth, 2000 - 2005

Region	**Ratio**
World	1.07
Africa	1.03
East Asia	1.14
Of which, China	1.15
Republic of Korea	1.10
South-Central Asia	1.07
Of which, India	1.08
South-Eastern Asia	1.05
West Asia	1.05
Europe	1.05
North America	1.05
Oceania	1.05

Source: United Nations (2006). World Population Prospects: the 2006 Revision.

Table 5: Trend in level and inequalities in under 5 mortality in 22 developing countries

Country (years) a/	Overall under 5 mortality			Ratio of mortality on the bottom and top quintiles		
	Level of under 5 mortality per 1000 births			Rate ratio		Change in rate ratio c/
	earlier year	later year	% Change in level of under 5 mortality	earlier year	later year	
Countries with declining under 5 mortality b/						
Bangladesh (1996-7; 2000)	127.8	110.0	-13.9	1.86	1.93	..
Benin (1996; 2001)	183.9	162.7	-11.5	1.89	2.13	Increase
Colombia (1995; 2000)	37.4	28.0	-25.1	2.21	1.94	Decrease
Egypt (1995; 2000)	95.9	69.2	-27.8	3.76	2.91	Decrease
Ghana (1993; 1998)	132.8	110.4	-16.9	2.08	2.66	Increase
Guatemala (1995; 1998-9)	79.2	64.6	-18.4	2.35	1.97	Decrease
India (1992-3; 1998-9)	118.8	101.3	-14.7	2.85	3.11	..
Malawi (1992; 2000)	239.7	202.7	-15.4	1.47	1.55	..
Namibia (1992; 2000)	91.8	60.2	-34.4	1.46	1.76	Increase
Nepal (1996; 2001)	139.2	108.4	-22.1	1.89	1.92	..
Nicaragua (1997-8; 2001)	56.0	44.6	-20.4	2.32	3.35	Increase
Turkey (1993; 1998)	80.5	59.7	-25.8	4.6	2.61	Decrease
Zambia (1996; 2001-2)	192.1	167.9	-12.6	1.57	2.07	Increase
Remaining countries						
Cameroon (1991; 1998)	144.0	146.3	1.6	2.46	2.29	..
Haiti (1994-5; 2000)	140.6	137.7	-2.1	1.55	1.51	..
Kazakhstan (1995; 1999)	47.9	63.0	31.5	1.21	1.83	Increase
Mali (1995-6; 2001)	252.2	238.2	-5.6	1.78	1.67	..
Peru (1996; 2000)	68.4	60.4	-11.7	4.98	5.26	..
Tanzania (1996; 1999)	144.8	161.1	11.3	1.44	1.18	Decrease
Uganda (1995; 2000-1)	156.2	156.5	0.2	1.69	1.80	..
Vietnam (1997; 2000)	45.9	32.9	-28.3	2.75	3.35	Increase
Zimbabwe (1994; 1999)	75.9	90.3	19.0	1.50	1.60	..

Source: Moser, Kath A et al. (2005) "How does progress towards the child mortality millennium development goals affect inequalities between the poorest and least poor? Analysis of Demographic and Health Survey data", *British Medical Journal*, vol. 331 (19 November), pp 1180-1182.

Notes: a/ Years that Demographic and Health Surveys were conducted

b/ Statistically significant declines

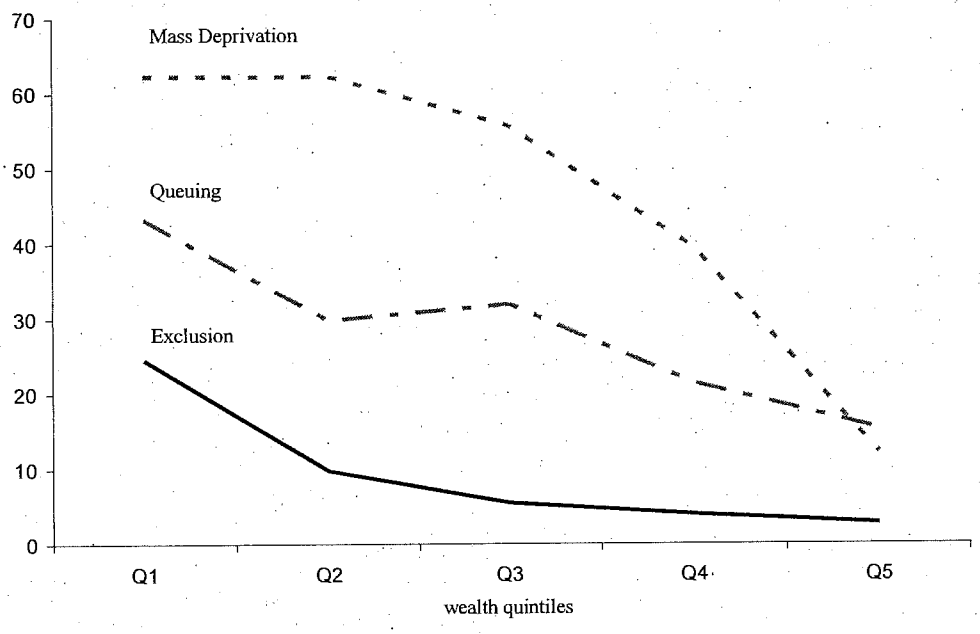
c/ Rate ratio increase or decrease of at least 10%. Change less than 10 per cent is indicated by " "

Table 6: Leading cause of deaths in low income countries, 2004

Disease or injury	Deaths (millions)	Percentage of total deaths
Lower respiratory infections	2.9	11.2
Ischaemic heart disease	2.5	9.4
Diarrhoeal diseases	1.8	6.9
HIV/AIDS	1.5	5.7
Cerebrovascular disease	1.5	5.6
Chronic obstructive pulmonary disease	0.9	3.6
Tuberculosis	0.9	3.5
Neonatal infections	0.9	3.4
Malaria	0.9	3.2
Prematurity and low birth weight	0.8	3.2

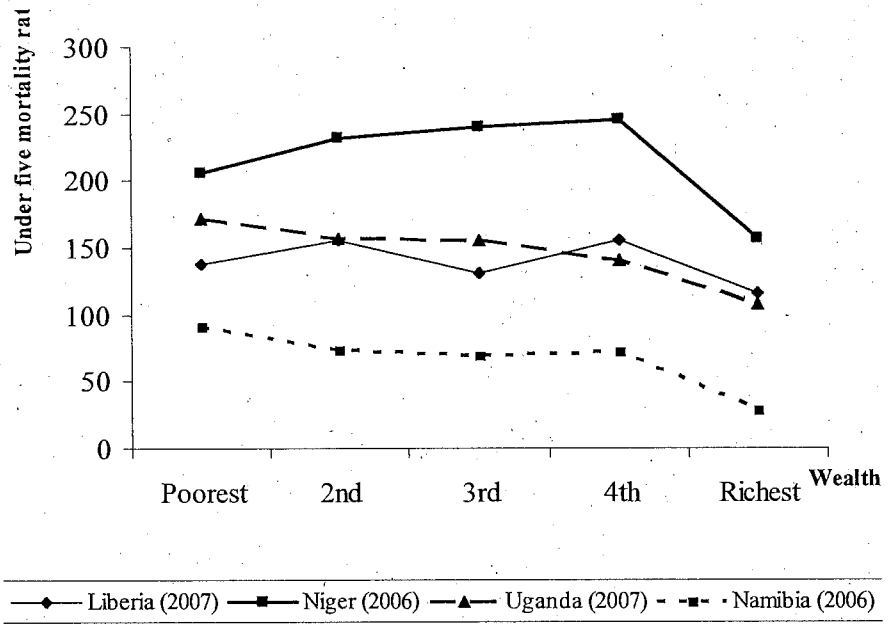
Source: WHO, Global Burden of Disease 2004

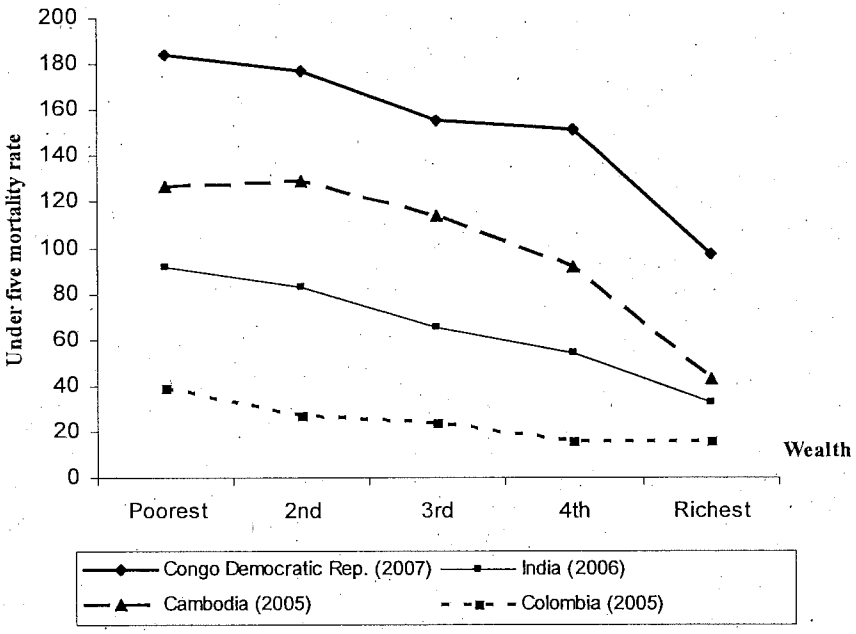
Figure 1: Under-5-Mortality rates across wealth quintiles.



Source: UN/DESA.

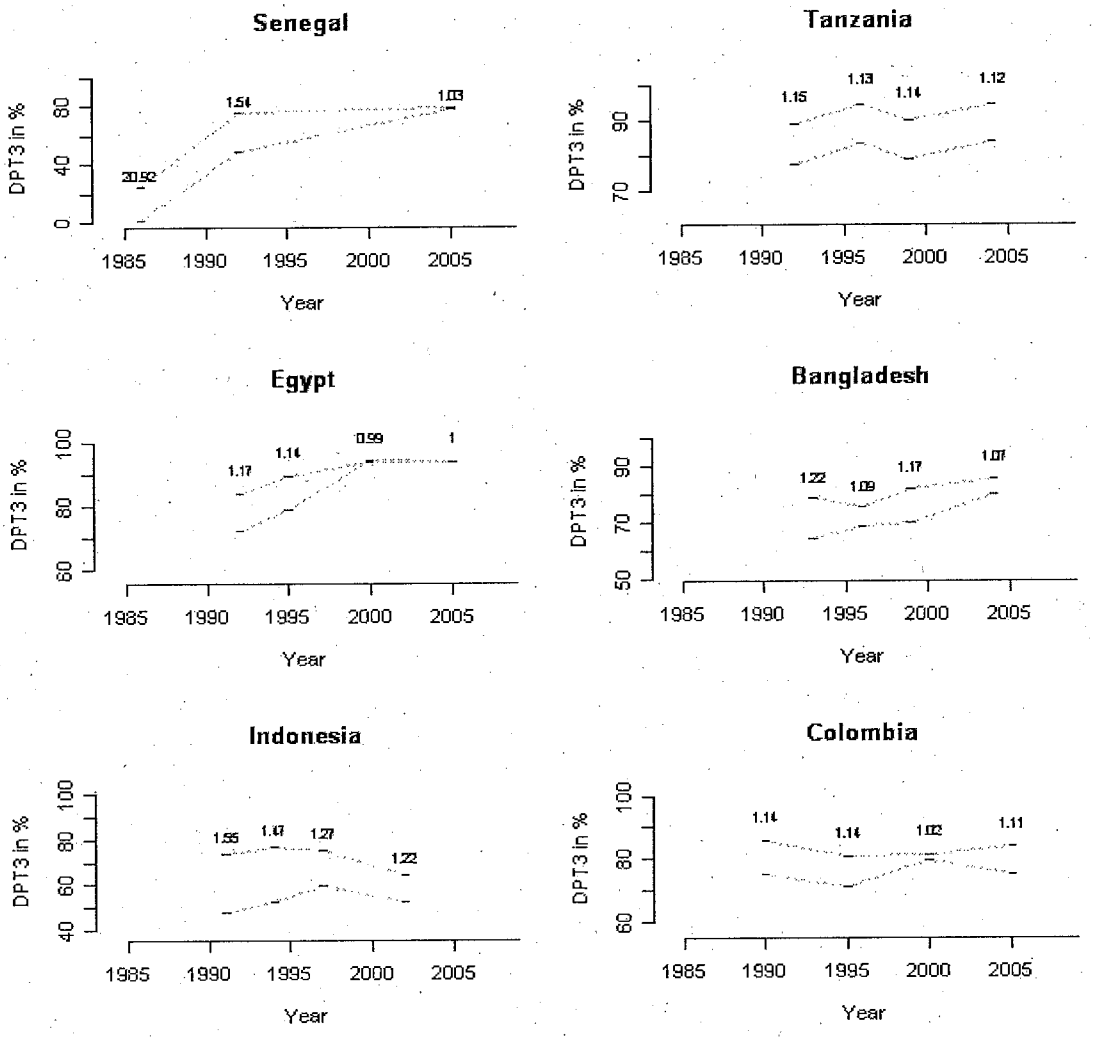
Figure 2: Under five mortality rates per 1000 children by wealth quintile





Source: UN/DESA, based on the Demographic and Health Survey (available at http://www.measuredhs.com/accesssurveys/start.cfm).

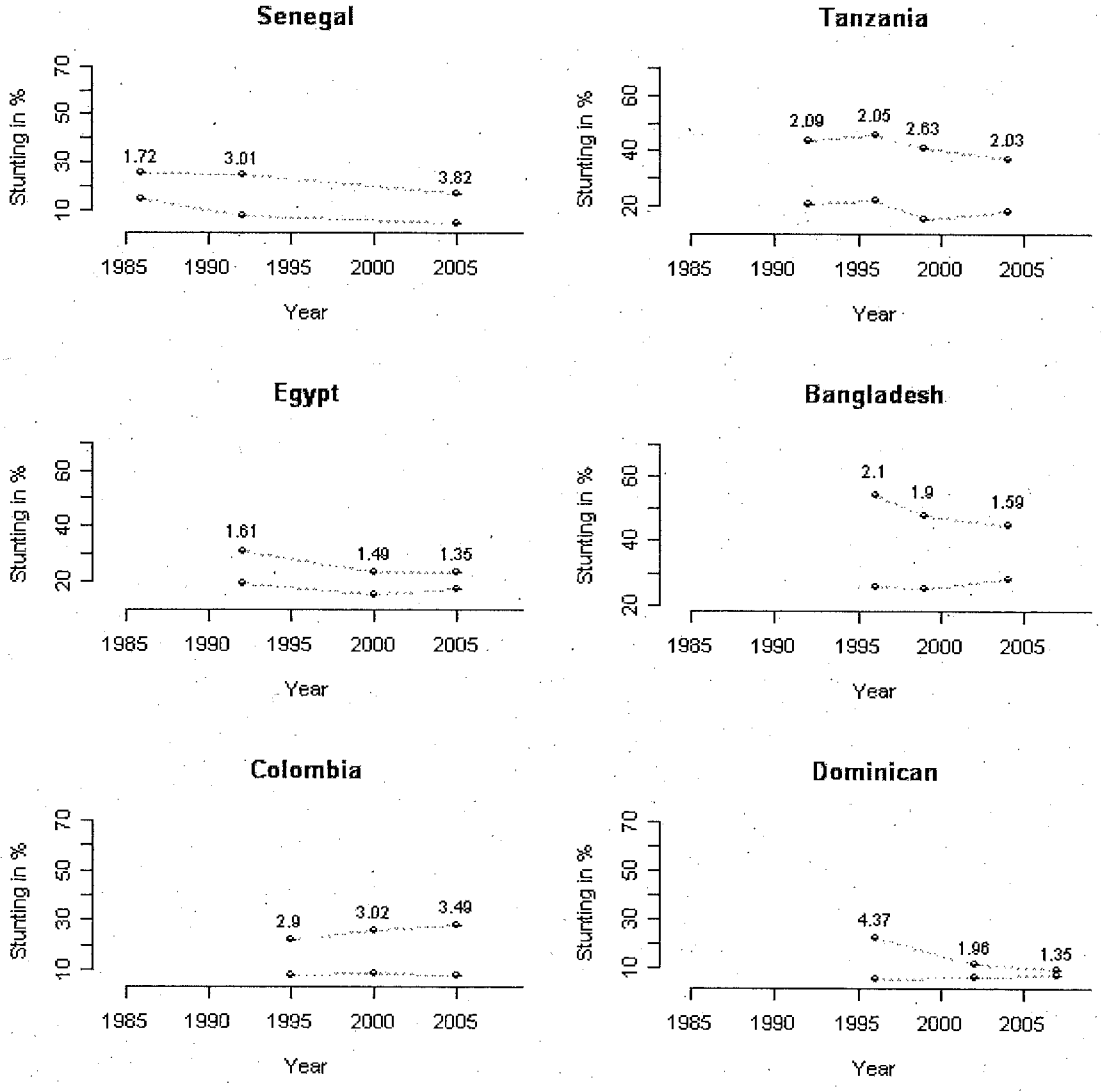
Figure 3: Trends of DPT3 immunization levels in urban and rural areas, 1985 – 2005 (per cent).



Source: UN/DESA, based on the Demographic and Health Survey (available at http://www.measuredhs.com/accesssurveys/start.cfm).

Note: Upper line = urban areas; lower line = rural areas, and; the number in the figure = ratio between urban and rural areas.

Figure 4. Stunting in households with mother with no education and with secondary education, 1985 – 2005 (per cent) a/



Upper line = mother with not education; lower line = mother with secondary education, and; the number in the figure = ration between mothers with no and secondary education.

Source: UN/DESA, based on the Demographic and Health Survey (available at http://www.measuredhs.com/accesssurveys/start.cfm).

Note: a/ Stunting is defined as having a height-for-age more than 2 standard deviations below the median of the National Center for Health Statistics/World Health Organization growth reference.

Committee for Development Policy
Report on the eleventh session (9 – 13 March 2009)

Chapter on Global Public Health

[Preliminary Draft/Summary of Background Study]

[Secretariat's draft]

[Please note final draft is under tight word limit: maximum of 2,500-2,700 words. Current version: 3,000]

The Economic and Social Council decided that the Annual Ministerial Review (AMR) in 2009 would review "implementing the internationally agreed goals and commitments in regard to global public health". In assisting the Council, the Committee for Development Policy established that the main objective of its contribution to the 2009 AMR was to examine ways in which global health partnerships (GHPs) – an innovative yet important vehicle for international cooperation -- could support developing countries in achieving improved health outcomes for all.

Taking into account the wide range of factors underlying public health, focus is placed on health inequalities and the impact of GHPs in recipient countries. The Committee considered that international assistance should be designed not only to make progress at the national average of health outcomes, but also in a fair and equitable manner. This chapter will thus examine the current status of health inequalities, its implications for attaining the Millennium Development Goals (MDGs) and the impact of GHPs on achieving the MDGs through the "equity lens". The capability of health is a precondition of all other capabilities: where health inequalities are large, the poor is most likely to be experiencing other types of inequalities.

A. Why health inequalities matter for achieving the internationally agreed goals

First, large health inequalities across countries indicate the need of making further progress.. A significant share of the populations of many developing countries still suffers from preventable and/or easily treatable diseases because access to health care services is severely restricted, owing to insufficient infrastructure, the lack of financial resources or social impediments.

Second, health inequalities within nations are often as great as, or even greater than, inequalities across countries and this fact has significant implications for achieving the internationally agreed Goals. In the absence of well targeted efforts to provide necessary health care services for worse-off groups (such as the poor, people living in remote areas,

a particular gender or an ethnic group), achieving a particular average target does not necessarily lead to improvement in living conditions of all.

A major effort by official donors and global health partnerships (GHPs) to improve health in developing countries would better attuned with the spirit of the Millennium Declaration if their programmes and projects explicitly incorporate in their objectives the reduction of inequalities in health and other pertinent areas.

The link between achieving the MDGs and health inequalities is rather complex. Available information on 22 developing countries with respect to under-five-mortality, for instance, indicates that improvements inU5M rates in line with the MDGs do not necessarily bring about decreasing inequalities in mortality between the poorest and richest. [1] In fact, in 5 countries where overall U5M improved the gap between rich and poor widened. Efforts to achieve the MDGs may increase inequalities, with the better-off benefiting disproportionably more than their disadvantaged counterparts.[2] This is largely because it is often more difficult for the health authorities to extend services to the worse off, who more likely live in distant or hard to reach areas. Reaching these groups requires efforts beyond health interventions.

Third, the existing inequalities in health in a nation reflect the interplay of cultural, political and economic forces. Development partners need to ensure that their programmes take account of and address the existing inequalities. When aggravated, inequalities – not only in health, but also in other fronts – can become a source for social unrest or conflict.

The above considerations are consistent with the main recommendations of the Commission on the Social Determinants of Health[3]. The Commission indicates the urgent need to improve daily living and working conditions for better health outcomes, which requires tackling the inequitable distribution of power, money and resources. Inequity is shaped by social structure and processes that need to be changed.

B. Health inequalities: underlying factors and evidence

The Committee notes that despite progress, the availability and quality of data on health conditions is still not adequate particularly in low-income countries. Largely owing to financial and administrative constraints, only a few low-income countries are capable of maintaining death, birth and disease registries. Because of the lack of reliable data, the extent of inequalities in health is not well understood.

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[1] Moser, Kath A. et al. (2005). "How does progress towards the child mortality millennium development goal affect inequalities between the poorest and least poor? Analysis of Demographic and Health Survey data", *British Medical Journal*, vol. 331 (19 November), pp. 1180-1182.

[2] Gwatkin, Davidson R. et al. (2004), "Making health systems more equitable", *Lancet*, vol. 364 (October 2), pp. 1273-1280.

[3] Commission on Social Determinants of Health (2008), Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health (Final Report of he Commission on Social Determinants of Health (Geneva, WHO).

Despite limitations, available data indicate a relationship between poorer health of the worse-off (or the socially disadvantaged) and unequal distribution of income, wealth and other social factors, both globally and nationally.[4] Health status widely differs between developing and developed countries, but disparities are also considerable in terms of the amount of resources devoted to health: people in developing countries may spend less, in absolute terms, on health care services, but pay more, in relative term, from their own pockets or other private financing arrangements.

At the national level, social disadvantages replicate socio-economic status, gender, ethnicity and geographical area people live, which, in turn, reflects economic resources (income and wealth), education and occupation.

Household wealth is a significant measure of economic resources available for health care and there is a correlation between greater wealth and better health outcomes. For example, children born in poorer families face higher probability—in some countries three times higher--of dying before reaching age 5 than those from richer families in 54 out of the 55 developing countries. Similarly, education is also positively correlated to heath: a child with better educated mother is more likely to reach at age 5 than with less educated mother.

The type of occupation is partly associated with occupational hazards, but health outcomes also differ according to employment grade or rank. The type and quality of job can also affect health indirectly through income security and access to health insurance.

Discrimination against specific racial, ethnic or religious groups is known to have serious health and social consequences. Health inequalities also occur across space, partly owing to natural differences in the risks and exposures in different geographic contexts as well as to differences in the availability of and quality of services rendered by health care facilities.

These social determinants of health are often conveniently summarized using the acronym "PROGRESS": Place of residence (urban/rural), Race/ethnicity, Occupation, Gender, Religion, Education, Socio-economic status and Social capital/resources.[5]

Among these determinants gender is a key variable in health. Gender disparities manifest directly in health status, as well as in access to health care, in health research and in the quality and kinds of health care services provided. Gender inequalities work in a manner that interacts with other types of inequalities arising from the factors in the PROGRESS.

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[4] Commission on Social Determinants of Health (2008), op. cit., p.1.

[5] Evans. T. and H. Brown (2003). "Road traffic crashes: operationalizing equity in the context of health sector reform", *International Journal of Injury Control and Safety Promotion*, vol. 10, No. 1 & 2, pp. 11 – 12.

The costs of not attending to the effects of gender while responding to global health challenges are immense.[6]

C. Global health partnerships

International development assistance on health has accelerated since the launching of the Millennium Development Goals in 2000 and amounted to a total of $12.6 billion worth of commitments in 2006 by both bilateral and multilateral donors of the Development Assistance Committee of the Organization for Economic Cooperation and Development (OECD/DAC). There have also been significant changes in the pattern of resource allocation within the sector. While HIV/AIDS and infectious disease control absorbed about 20 per cent of the ODA commitments in the 1990s, these programmes accounted for 51 per cent of all commitments in 2005-2006. On the other hand, the share of general health (health policy, training and research) declined from 36 to 18 per cent during the period.[7]

A proliferation of new actors and new institutional arrangements has been noticeable -- between 80 and 100 international alliances have been created with various objectives. The World Health Organization (WHO) has identified these alliances among public institutions (national or multinational), civil society organisations, philanthropic foundations and private companies — called global health partnerships (GHPs) — as a key of achieving significant improvements in the field of health on an international scale.

Most GHPs have multiple objectives and take a disease-specific approach in their health programs. In fact, around 60 per cent of them target three diseases, namely, HIV/AIDS, tuberculosis and malaria. There are also GHPs devoted to the eradication of diseases which are less well-known and about which the general public is less aware, such as Dengue, Chagas, guinea worm, and others.[8] Only a small number of GHPs are designed to strengthening national health services.

The emergence of GHPs has had both positive and negative effects on the capacity of developing countries to tackle health problems. On the one hand, partnerships function acceptably well, especially in terms of overall improved access to treatments, therapies and medicines. On the other hand, there are concerns about the role of GHPs in addressing heath inequality, their impact on national health systems and on the coherence of the international aid architecture.

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[6] Gender disparities, although overwhelmingly common in relation to women, may also be present against men. For example, that average life expectancy fell in the Russian Federation in the 1990s and the decline was sharper among men than women.

[7] OECD, Measuring aid to health, October 2008; and OECD, Recent trends in official development assistance to health, 2006

[8] Ito, B (2007): "Global Health Partnership and Funding System", en H. Uchimura (Ed), *Health Service and Poverty: Making Health Services more Accessible to the Poor*, Institute of Developing Economies

2. GHPs and the promotion of equality

GHPs have become important vehicles to achieving the health-related MDGs. While GHPs have been designed to undertake specific tasks, they function in and impact upon an socio-cultural and policy environment that needs to be taken into account when designing their interventions in order to ensure that all in need are reached.. In principle, there are four channels through which the relationship between GHP and equity may be considered. Firstly, through the relationship between poverty and diseases and geographical areas where the GHPs operate; secondly, through the selection of beneficiary countries for the GHP; thirdly, through the impact on national health services; and, fourthly, through the working procedures followed by the GHP in the countries where they operate

(i) Tackling the poverty-disease nexus

There are clear inter-linkages among incidence of poverty, other types of inequalities and a large share of the diseases and areas targeted by the GHP. Health specialists recognise that individuals have different capacities of benefiting from health care services, even if they are provided equitably. In addition, the provision of services does not reflect the actual use of those services by different sectors of society. There is ample evidence that improvements in the access to antiretroviral treatments in Africa, for example, do not necessarily lead to the actual use of those treatments by many people. In order to ensure that provision benefits all, it is necessary to address the social conditions within which people live and work. By starting with these structures, not only can improvements be made to the socioeconomic factors associated with health, but the treatments can also be adapted to the specific conditions (both social and cultural) of each group.

Additionally, there is no guarantee that the investment in health care is targeted to poor people. In fact, there is evidence that the rates of use of standard primary health care are higher in upper socioeconomic groups than in lower groups[9] The poor requires greater effort to be reached because of their limited resources and ability to use even heavily subsidised health services.

(ii) Allocation of resources: poor countries, diseases of the poor

GHPs can address inequality by focusing on the poorest countries. GHP are oriented mainly to fight against infectious disease, 90 per cent of which are reported in developing countries, whereas these countries account for only 12 per cent of global expenditure on health. GHP activity and resources are mainly oriented to poorer geographical areas, especially sub-Saharan countries.

[9] Gwatkin, Davidson R. *et al.* (eds.) (2005). *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What doesn't and Why*. Washington, D.C.: World Bank.

While this is encouraging, it does not guarantee—except in mass campaigns—that the disadvantaged groups will be reached. Additionally, despite the important achievements in HIV/AIDS, it should be recalled that today the top killer diseases in most poor countries are respiratory and intestinal diseases leading children to death from pulmonary failure or diarrhoea In some countries, GHPs emphasizing a single disease may unintentionally be addressing the needs of small groups to the detriment of the majority. For instance, in Mozambique AIDS prevalence rate is relatively low but funds allocated for the disease is 2.5 times larger than for malaria and 46 times that for childhood diseases, which affect a larger share of the population. In Uganda, the very rapid increase in allocations to address HIV/AIDS has pulled medical personnel from other parts of the health sector compromising delivery of services.[10]

(iii) Impact on national health services

The effective and equitable eradication of the diseases targeted by the GHPs depends on the ability of the national health systems to integrate preventative, diagnostic and therapeutic measures in the sphere of primary health care, which is frequently inadequate in low income countries.

In fact, problems often arise due to GHPs' limited attention placed on strengthening the national health systems and in the impact these funds can have on the capacities, both in terms of human and technical resources, of the national systems. While some GHPs have committed resources to strengthen local systems, these resources are often earmarked to services and institutions related to a specific disease to which the GHP is targeted.[11]

In other instances, GHPs have attracted health professionals away from the public sector—which is already facing considerable shortages of skills—to higher paid positions within the GHPs. Furthermore, the vertical nature of their approach creates a new type of front-line healthcare workers with very specific skills, which may not correspond to the overall needs of the country. As observed elsewhere, "there is a serious risk that weak human resource and systems capacity at central and local levels can be overwhelmed by the growing proliferation of GHP –and other HIV/AIDS initiatives- with separate demands".[12]

(iv) Adjusting working procedures

It is not possible to make progress on health equity if this objective is not explicitly incorporated into the definition and design of the interventions. Without strong links to poverty reduction processes, scaling up aid may not have as strong positive impacts on health equality. At the same time, the use of generalized procedures "one size fits all" by

[10] World Bank (The Global Programs and Partnership Group. Concessional Finance and Global Patnerships Vice Presidency) Global Funds at the Country Level: What Have We Learned? (July 2008)
[11] See for instance, The Global Fund, Fact Sheet: The Global Fund's approach to health system strengthening, Global Fund Fact Sheet series, 5 of 5, 1 March 2008.
[12] DFID (2004): *Assessing the Impact of Global Health Partnerships*, DFID Health Resource Centre.

the GHPs has not helped develop grass root approaches which are sensitive to the conditions of the poorest

Without strong links to poverty reduction processes (and adherence to the Paris principles of aid effectiveness), scaling up aid may not have as strong positive impacts on health equality. GHPs are no exception. GHPs should be explicitly linked to the Poverty Reduction Strategy Papers (PRSPs) while the latter should also take into account the need to create additional "fiscal space" for health – i.e., space in the public budget to scale up health. Additionally, macroeconomic stability still dominates PRSPs' concerns, which constrains increasing expenditures in health.

E. Conclusions and Recommendations

Inequality matters for achieving goals of global public health: numerical targets can be met while many are left behind. The less privileged members of society are often bypassed. Moreover, the health status of the population is the result of the complex interaction of a wide range of factors which go beyond the jurisdiction of health authorities. Improving health outcomes in a sustained and equitable manner goes beyond the simple provision of health care and demands corrective action on the social factors which determine people's health conditions.

Accordingly, it is necessary to integrate social and gender considerations and to address existing inequalities in making health care available and accessed by those who need it. At the national level, health systems should be strengthened by improving the quality and increasing the supply of primary care and guaranteeing access.

Health-related policies and other interventions at the national and international levels need to be introduced to reduce inequalities in health. These include:

i. Adjusting the aggregate health goals to reflect the need to address existing inequalities.
ii. Introducing inequality impact assessment for interventions in the health sector.

These measures would draw attention to the inequality implications of proposed actions by local authorities and by the international cooperation. An indicator on health inequality can be added to the MDGs, so that the international community seeks to monitor impacts of health interventions on the distribution of health.

While vertical approaches are useful and have a role to play in the supply of health care, the effectiveness of interventions by GHPs needs to be improved. It is necessary to go beyond having a disease-specific focus and to include measures that address social and gender inequities when establishing operational targets.

The best approach requires that recipient and donor governments keep an integral view of the health system, giving priority to primary attention and the strengthening the institutional and technical capacities of the system. GHP should adapt to that logic, and ensure that its actions do not weaken (or fragment) the national health system.

At the operational level, there are four areas of improvement that should be taken into account by the GHPs: (i) adoption of the principles of the Paris Declaration (especially the ones related to alignment and coordination to reduce the transaction costs); (ii) subordination of GHPs' operations to the recipient country's health system, preserving the leadership of domestic governments in addressing health issues at the local level; (iii) revision of their structures of governance; and, (iv) greater efforts to technical assistance tasks, as a mean to correct the existing inequalities of countries.

At the same time, the creation of new GHPs should be restricted in order to avoid the further proliferation of uncoordinated actors within the international aid system and to channel the new proposals and resources through the already existing multilateral institutions.

Donors are required to review their criteria of aid allocation to guarantee that recipient countries are able to include GHP efforts in a coordinated way. Recipient governments, together with donors, should make GHP interventions responsive to the specific characteristics and needs of national health systems. In some cases, this could mean the review of the contributions donor countries make to GHP in the benefit of a greater support of recipient countries´ budgets, thus reinforcing sector wide approaches (SWAPs) and/or the poverty reduction strategies.

Lastly, the availability and the quality of the existing data on health need to be improved. The provision of credible and comparable data should strengthen the commitment and resolution to scale up efforts on public health at the global and national levels. The inter-agency activities on the MDGs could be a good basis to providing guidance and building database on indicators on health inequalities.

The Climate Change-Development Nexus: elements towards a CDP-position paper

J.B. (Hans) Opschoor

This paper presents an action-oriented resume of development-relevant aspects of proposals made in the context of BAP related to international financial resources for responding to climate change. Further details (including references) can be found in the background document: Development and Climate Change Related Financial Resources (Draft). CDP is asked to scrutinize and elaborate the suggestions presented below (in italics), and to bring them to the attention of parties negotiating in the BAP context – apart from their incorporation in the Report of CDP-11.

I. Introduction

Climate change (CC) is a priority issue in international efforts towards making development sustainable. These efforts combine concerns over 'equity' (especially poverty reduction) and 'ecology' (i.e. the availability of resources and the preservation of environmental quality) – in addition to the usual concerns with effectiveness and efficiency. Climate change asks for co-operative response by a wide range of actors at all levels. The Bali Action Plan (BAP, 2007) of the UNFCCC Conference of Parties (CoP) articulates the current attempts as developing an internationally concerted response to climate change (to be achieved by the end of 2009), in terms of (i) adaptation, (ii) mitigation, (iii) technology development and transfer, and (iv) finance. Here we address equity and development aspects of the latter in sections on: international co-operation and national action (section 1), CC-related financial flows (section 2), CC-related financial architecture (section 3), adaptation and national development planning (section 4), adaptation financing and ODA (section 5), and mitigation and development (section 6).

The discussions about a new global agreement to deal with the climate challenge take place in an international economic climate characterized by serious slowdowns in economic activity in many sectors and countries, and with severe development repercussions. However, there are important synergies to be expected from integrating climate and energy related investments into strategies dealing with the economic down-turn. In fact, the current economic situation might present opportunities to turn towards a carbon-poor, climate resilient and sustainable development – a turn likely to be needed even beyond economic recovery given the urgency of the climate issue. In this regard it is important to understand that an economic recession, even if it would lead to short term reductions in greenhouse gas emissions, is no answer to the climate challenge as such drops in emissions would soon be overtaken with economic recovery unless the turn mentioned above is actually made.

II. International co-operation, national action and development policy

To be effective in terms of curbing climate change and reducing vulnerability to climate change impacts, an internationally agreed and co-ordinated approach in line with the Bali Action Plan (BAP) is needed in terms of specific targets or aims, means and strategies. Given the scale of these efforts and in view of the principles underlying UNFCCC (especially the principle of common but differentiated responsibilities and capabilities) international cooperation will also be necessary at the level of funding the activities in adaptation, mitigation and technology development (and the associated capacity development). Internationally, and in the post-Bali process, a 'shared vision' on

how all of this is to be elaborated in a new international agreement is yet to be tabled. *CDP welcomes the intentions expressed at Poznan to lay down in this 'shared vision' (and in the subsequent agreement) a clear and strong commitment to the overall objective of sustainable development (cf. CDP 2008) and would like to emphasize that this vision must include a strong commitment to equity-related aspects such as poverty reduction and convergence in terms of income distribution. Indeed, a new global agreement will require equitable burden sharing.*

Whatever the outcomes of the international negotiations, part of the action they will give rise to in mitigation, adaptation and technology development and transfer will be at the national level. Enhanced national action will be necessary in all fields mentioned (cf. BAP). On mitigation, developed countries are to articulate commitments or actions including emission reduction objectives, whereas BAP specifies that developing countries are to identify "nationally appropriate actions" in the context of sustainable development, enabled by technology transfer, financing and capacity building (see also sections 2, 3 and 6). *Unless the global agreement ensures a fair approach to burden sharing any subsequent action on especially mitigation in and by developing countries might be insufficiently targeted or enforceable.*

On adaptation, exposed countries are to draw up adaptation plans and integrate these in their sectoral and national planning towards achieving climate resistant development, with international support (in particular the LDCs, SIDS, and ecologically vulnerable African countries). National action plans need to articulate which sets of policy instruments are most appropriate in enabling the realisation of national objectives (see section 4). National policies would also elaborate how countries intend to engage in, and use internationally available resources (see also section 5). *There is an emerging consensus that development countries' adaptation efforts are best mainstreamed into national and sectoral development policies and strategies, so as to ensure effectiveness and coherence with overall objectives of sustainable development.*

III. Climate Change-funding, investments and financial flows

CDP has emphasised the need for an investment-based approach towards technology development for adaptation and mitigation (CDP 2007, 2008). Deliberations in the BAP-process thus far have provided ample argument in favour of such an approach. It would have the additional advantage of contributing towards efforts to deal with the current financial crisis and its economic repercussions.

Given the differing responsibilities and capabilities there is a need for international funding of CC-related activities in developing countries. Enhanced action has been agreed to (see BAP) to improve access to adequate, predictable and sustainable financial resources and to provide new and additional resources including official and concessional funding for developing countries, for i.a. the development of plans of action, implementation (in mitigation as well as adaptation), capacity building, etc.

Enhanced action has also been agreed towards mobilisation of private sector funding and investment. Market mechanisms should be made to internalize costs associated with environmental and social externalities. Carbon-pricing is consistent with the Polluter Pays Principle and gives proper signals and incentives. It also has a revenue-generating effect which can help fill funds. Yet, it would not resolve all underfunding issues; moreover, there may be important equity considerations associated with it, as the income effects of it can be regressive unless these effects are mitigated or compensated.

At present, the needs – financial and otherwise - for such co-operative response far exceeds the means available. Crude and incomplete estimates of needs in developing countries are in the order of magnitude of US$ 250 billion p.a., the currently available official means are at about US$ 10-20 billion; concrete proposals discussed in the setting of CoP14 considered another US$ ~5 billion. A combination of market failure and policy failure has brought about this underinvestment and underfunding.

Options to address and remedy these failures do exist, but may be difficult to put in place for reasons of differences in appreciation of long terms risks, uncertainties and cost/benefits, diverging stakeholders' interests and power asymmetries. Wider ranging options that have been identified include taxes on capital flows or on international transport, energy use or emissions, volumes of transactions in carbon markets, permit-auctioning, GDP-related 'contributions', etcetera. Such mechanisms could generate flows at the levels of 10s-100s of billions of US$ annually.

In order to enhance the predictability of these flows contributions must not be voluntary but agreed long term commitments, based e.g. on *pro rata* mechanisms (such as levied percentages of financial flows, mandatory contributions in relation to income or production, etcetera). The relationship between such international funding and ODA will be discussed below (section 5).

IV. Financial architecture

A financial 'architecture' is to be constructed capable of generating adequate, new and additional means, and of delivering finance efficiently, effectively and equitably. Options considered in these respects differ in their development repercussions.

By 'financial architecture' is meant here: any set of financial mechanisms able to broaden the scope and scale of CC-related activities (adaptation, mitigation, capacity building, technology development and technology transfer), the arrangements to govern these activities and provisions for co-ordinating them. The current architecture is comprised of multilateral funds as operated by GEF (the Global Environmental Facility, as 'operating entity' under UNFCCC) and World Bank (WB), and a number of individual donor country operated initiatives (e.g. UK, Japan). A special Adaptation Fund has been established by CoP-UNFCCC, which, architecturally, is a step forward. In the contributions towards the post-Bali process a large number of initiatives have come forward (e.g. Swiss and Mexican proposals for setting up funds, WB and GEF initiatives).

Some of the new proposals would be under the Convention, while others would be outside it. Some proposals would generate funds internationally, while for others the funds would flow bilaterally, through national budgets. There are significant differences in governance arrangements and authority over these new funds. These proposals expand the scope and scale of the current elements in the financial architecture for climate financing; they also add elements to that architecture. There is a risk of proliferation and hence a need for synchronisation and co-ordination to ensure complementarity, adequacy (in terms of level and in terms of focus), policy coherence (vertically and horizontally), and additionality. *It seems prudent and pertinent for CoP to analyze the compatibility and consistency of flows through bodies directly under the CoP and from other sources and to explore possible differences in terms of explicit or implicit conditionalities imposed. Coherence (and synergy) is to also be ensured in relation to other international activities. CDP will continue to have an interest in these matters in a perspective of equitable and sustainable development.*

A new architecture would need to be built on, and handle, flows of finance mobilized according to objective criteria reflecting responsibilities and capabilities to contribute, and criteria for disbursement to eligible recipient countries.

The architecture would need to provide for new and additional – as well as predictable and stable – finance. It should ensure coordination and coherence with other bilateral and multilateral financial flows consistent with Article 11, paragraph 5, of UNFCCC; and enable the engagement of the private sector, to leverage additional resources. Furthermore:

- The system is to operate under the authority and/or guidance of UNFCCC, towards the full, effective and sustained implementation of the Convention and be accountable to the CoP;
- Governance is based in an equitable and geographically balanced representation by parties to the convention, and transparent decision making;
- Direct access by recipients is to be enabled and recipients are to be involved in all stages; priority is given to the most vulnerable countries.

In a development perspective, several of these principles (especially those on new, additional and predictable flows, equitable and balanced governance, and fair and adequate access) are pertinent and should be enshrined.

Involving 'entities' beyond or outside UNFCCC might possibly more quickly lead to more substantial pledges by some donor countries but might suffer from lack of support from large parts of UNFCCC's CoP, unless arrangements are made that ensure such other funding elements to operate under guidance from CoP. There also might be a 'credibility dilemma' here in that the managerially more convincing options and the more 'democratic' ones might not be the same. This might generate juxtaposition between donor countries and recipients and have repercussion for funding in terms of levels and/or timing for development financing.

In all, it seems appropriate and logical that the 'regie' in a new architecture should be from UNFCCC (and in line with the Bali Action Plan and at least consistent with the Paris Declaration) but set up in such a way as to optimize the levels of financial flows.

V. Adaptation and National Development Planning

Developing countries need to develop policies regarding their approaches related to adaptation (as well as mitigation), while maintaining their drive for development and poverty reduction. Such policies will contribute to an enabling environment for the involvement of all relevant sectors and societal groups in adaptation action, including perspectives on the facilitation of adaptation, including their capacities to deal with CC risks. Here the focus is on adaptation, in a perspective of climate resilient, sustainable development. Special attention is given to: (i) the role of National Action Programmes for Adaptation (NAPAs); (ii) risk management as part of mainstreamed adaptation-cum-development, and (iii) the measurement of (national) vulnerability.

V.1. LDCs, DCs and NAPAs:

NAPAs (National Action Programmes for Adaptation) were meant to identify the most urgent and immediate needs of a selection of exposed countries (LDCs and SIDS). They focus more on capacity

development for monitoring and management and on pilots than on full scale adaptation programmes. Thus, NAPAs are a first step towards the scaling up of adaptation and integration of climate change into national development plans. The LDC Expert Group on adaptation reported a need for "advice on how to revise priorities over time as vulnerabilities change and priority needs are addressed".

LDC parties will have to update their priorities by looking further into the future and identify adaptation needs taking into account updated climate scenarios over this longer time horizon. Secondly, adaptation also is important to developing countries other than LDCs; these too should elaborate adaptation action programmes and, develop and secure necessary means of implementing such programmes.

V.2. Risk-related aspects and National Policies

Currently, catastrophe risks typically are dealt with by a mix of social networks and informal post-event credit. Micro credit and micro-insurance allow local communities, civil society groups and municipalities to implement adaptation actions themselves, by providing them with access to small-scale grants and loans. Lack of insurance options may block development, e.g. as the risks of investing in the absence of (forms of) insurance can be too high to economic actors.
New, often market-based insurance mechanisms have been proposed for individuals and groups (aided by national policies in terms of information, awareness raising, insurance market creation etc), as well as insurance strategies at the level of individual countries and at the level of groups of countries (such as SIDS, LDCs and countries in Africa), and internationally operative climate change risk management mechanisms for (otherwise) uninsurable and long term risks.

National policies should encourage the development of mechanisms for financial risk sharing and management (including, where possible, private sector based mechanisms) that can be accessed by people and other economic agents, especially in LDCs, SIDS and countries in Africa, and help them to reduce their vulnerability to the impacts of CC. Meanwhile social mechanisms providing effective risk sharing and self-help should be strengthened.

V.3 Vulnerability Indicators

New international approaches to adaptation require vulnerability mapping, domestic national capacities for scenario assessment, as well as capabilities in exploring and designing adaptation options. GEF has observed that adaptation and vulnerability are in need of indices that capture /reflect these categories in simple metrics. The applicability could be explored of (national) vulnerability indicators in more objectivized approaches to adaptation funding: any allocation of adaptation funding between receiving countries will need to reflect a combination of factors including exposure to climate change, impacts of climate change; vulnerability to those impacts; capacity for adaptation (locally, regionally, nationally), etc. At this stage there is no such index or indicator.

It is desirable that a climate impact vulnerability indicator is developed by appropriate UN bodies, possibly in consultation with the Commission for Sustainable Development and Expert Groups on Adaptation in LDCs and SIDS.

VI. Adaptation Financing and ODA

International funding for adaptation in developing countries flows mainly through: (i) dedicated multilateral adaptation funds, and (ii) official development assistance (ODA). Regarding the first channel, most of the dedicated funds are under the GEF. At present, a new Adaptation Fund is being set up, as we saw, based on a systemic mechanism: a levy of 2% on CDM-monetized emission credits. Here, the focus is on ODA-based funding of adaptation action in developing countries.

The rationale for and ODA-based approach has been that much adaptation can indeed be seen as development aid: part of the adaptation activity addresses driving forces behind vulnerability – notably poverty and lack of opportunity. This has led to the suggestion to mainstream adaptation into development and development cooperation. From a sustainable development policy point of view this appears appropriate as such an approach is more efficiency-, effectiveness- and equity-prone. However, as this strategy would gain ground, the share of ODA-funded adaptation might tend to grow, and this might trigger resistance as it would divert ODA funds away from other development objectives. Moreover, given the magnitudes of the adaptation funds needed in developing countries, wanting to fund adaptation from ODA would entail a demand almost as large as current ODA flows.

Developing countries call for new and additional support for the climate change-related, new threats to livelihoods and development – in fact: to compensate for damage done or to be expected due to processes beyond their responsibilities or control - which is qualitatively different from financial flows related to the realization of the MDGs (i.e. ODA). Furthermore, mainstreaming adaptation into development in terms of funding might impose conditionalities on to what should be a country-owned process. To the extent that adaptation funding is compensation owed on the basis of the principle that the historic polluter should pay (or some similar logic) this justifies greater control over disbursement than rather would be the case with donor-driven mechanisms.

CDP finds the arguments for mainstreaming 'down stream', i.e. in the policy articulation of the recipient developing countries, convincingly strong. Furthermore, it finds that the finance-related issues discussed above suggest that, at the 'up stream' end of the funding link, development and adaptation flows should be separated. One option is, to put certain activities in ODA-funded programmes and to put others under some new budgetary facility under international co-operation, for CC. *Adaptation* (while of a ' joint-product" nature in terms of the benefits it delivers) *requires new and additional, as well as predictable, non-voluntary finance; on balance transparency may render it best to have two streams under separate heading (even though some elements of adaptation funding may appear in the development/ODA stream).*

VII. Mitigation and Development

Avoiding the risks of dangerous CC requires that emissions are to peak within the next fifteen years and are halved relative to 1990 by 2050. The industrialized countries are to take a lead in mitigation and international co-operation towards it. Given the expected economic growth and associated emission levels, it is inevitable that a significant part of these cuts is to take place in developed countries - notably (though not exclusively) in the so-called 'developing major economies'.

VII.1. Mitigation Action and National Development Planning and Private Sector Involvement

Developing countries have agreed to engage in "nationally appropriate mitigation actions" (NAMAs) in the context of sustainable development" (BAP 1.b.ii), with positive incentives for their enhanced implementation of national mitigation strategies and adaptation action (BAP1.e.ii) in line with sustainable development policies (BAP1.e.iv). *Like adaptation, mitigation efforts should also be come incorporated in development planning to draw the full sustainable developmental benefits of them.*

Private sector and market-based (or: originated) funding will be a necessary and important main source of finance and investment. Substantial shifts in private sector investment patterns will be required to mitigate and adapt to CC, globally and also in developing countries. In the power sector investment must be shifted from fossil-fired generation to renewables and possibly other options like Carbon Capture and Storage. Shifting investments will require financial incentives. A well-working international carbon market would further efficient emissions reductions; and so would effectively implemented reduction targets. The cheapest mitigation options often can be found in developing countries, which should however be ensured of the full net societal benefits that can be reaped. *National development planning should create conditions in which private (domestic and foreign) investment would generate the benefits in terms of sustainable development that are offered by the technological and ecological options available.*

VII.2. Spillover Effects of Mitigative Action

Response measures in the area of mitigation may lead to (spillover) effects: negative or positive co-benefits at national level related to transboundary impacts of mitigation elsewhere. Specifically, mitigative action in response to CC in Annex I countries could lead to spillovers in developing countries. This includes impacts from mitigation-induced shifts in investment patterns. Potential environmental, economic and social spillover effects include: loss of export revenue and market share (or, more generally, impacts on terms of grade and investment flows), loss of food production, health and environmental quality impacts, energy security, poverty alleviation and economic growth impacts, social benefits and losses.

Attention must be given in this work to (differences in) distributional repercussions of (different ways of effectuating) Carbon pricing. Secondly, analyses tracing impacts along a number of key product chains may be a rapid step forward. It also may be very fruitful to link work in this field to the Nairobi Work Programme on adaptation to be linked to this. Also, attention is needed for capacity development regarding the monitoring and assessment of the impacts considered here.

VII.3. "Differentiation"

UNFCCC distinguishes between developing countries (non-Annex I) and developed ones (Annex I; the latter further distinguished into the OECD countries -Annex II- and other). These categories reflect conditions as prevailing in 1992; re-consideration of them at some intervals, and of the lists of countries eligible to become recipients, seems appropriate. A discussion has emerged regarding further differentiation. The issue is pertinent as even when Annex I countries were to stop all emissions by 050, in that year developed countries would emit 49 GtCO2e, which is 10 GT above the global 2005 emissions, and clearly these emissions are distributed very unevenly. However, the developing countries generally reject differentiation. They point out that developed countries are historically responsible for most of the Greenhouse Gases in the atmosphere and that they should therefore be the only ones to undertake binding commitments to reduce emissions. Nevertheless, and

in line with the logic presented above, a group of "major developing economies" has in Hokkaido factually moved in the direction of accepting responsibilities as part of their nationally appropriate actions; some have committed to declining emissions after 2030-35 and indicated readiness to do more if and when international support is forthcoming.

The grounds for differentiation in responsibilities in UNFCCC are different levels of historical responsibility and of capability. This then led to the Annex I-Non-Annex I distinction. The BAP goes some way towards also recognizing special sub-categories amongst the developing countries (cf. similar sub-categorizations in UNFCCC), like 'particularly vulnerable countries, LDCs, SIDS, certain categories of African countries, etc. Outside UNFCCC, income or development-related classifications of developing countries are used (e.g. High Income Developing Countries, Middle Income Developing Countries, Low Income Developing Countries, Least Developed Countries).

Non-Annex I countries object to their group being split up in further divisions at the risk of losing influence in international climate negotiations. At the same time, they are far from homogenous in terms of development levels and contributions to greenhouse gas concentrations, and do have divergent interests (oil producers, islands, land locked countries, etc). It might be possible (and desirable) to look for options to enable mitigation efforts to be shared between those countries that are *capable* to undertake them and historically *responsible* (i.e. Annex I countries) and those who, related to their contributions to current and future commitment, show significant *potentials* to mitigate. This new way of looking at countries is also suggested in "climate development rights"-based approaches differentiating between responsibilities according to household income stratification rather than to national average incomes.

Various criteria and parameters for differentiation between countries in general including developing countries have been suggested, including HDI, GDP (total and per capita) and share of world emissions. Differentiation thus seeks to reflect diverging circumstances across countries. In order to ensure equitability in this, historical contributions to accumulated emissions should be a paramount consideration. Under differentiation a variety of NAMA-menus could be considered ranging from fixed and binding emissions targets, via non-binding approaches (no-lose targets) and sectoral crediting mechanisms, to CDM and – at the other end - Sustainable Development only. OXFAM suggests a "graduated set of commitments and actions for different countries" that measurably contributes to the global effort but which is premised on a trust-building approach providing incentives for such actions. Stern (2008) has proposed a solution in which commitments of developing countries may evolve towards binding national targets by 2020, but before developing countries take on such targets: (a) developed countries should have agreed to, and proven, their commitment and effectiveness; and (b) developed countries must transfer resources and technologies to developing countries. Meanwhile participating middle income developing countries could want support to help push emissions well below business-as-usual levels.

Ways to address the need for mitigation action beyond the division into 'developed' and 'developing' countries, should be explored with a view of effectuating a fair and development-oriented sharing of responsibilities. They could be based on mitigative potentials whilst retaining entitlements to development for those with low incomes, in addition to (and whilst retaining) those laid down in the Principle of Common but Differentiated Responsibilities and Capabilities. CDP would look at such proposals in terms of their contribution to equitable and sustainable development.

The global financial crisis and eastern Europe
Milica Uvalic
Policy note for the UN Committee for Development Policy
(New York, March 9-13, 2009)
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The global financial crisis is seriously affecting post-communist countries in eastern Europe (EE), though with more than a year delay. Many of the new EU member states and transition countries in southeast Europe and the Commonwealth of Independent States (CIS) risk the worst economic crisis since the early 1990s, when the transition to a market economy brought an unprecedented recession caused by economic and monetary disintegration, systemic vacuum and inappropriate policies (in particular over-shooting of macroeconomic stabilization). The EE countries appear to be among the most vulnerable groups, for a series of specific reasons. Although the factors and degree of vulnerability are different for each country, there are also some common grounds for concern.

Main factors of vulnerability

1. *External imbalances*: Most EE countries are heavily dependent on foreign resources for financing external imbalances. Except for Russia and a few other CIS countries, where exports of energy and natural resources have secured comfortable surpluses, all the other EE countries have had high, often increasing, current account deficits, frequently well above 10% of their respective GDPs - in 2008, the case of 16 out of the 28 EE countries - particularly Estonia, Latvia, Lithuania, Bulgaria, Romania, Hungary, Ukraine, Serbia and Montenegro (EIU, 2008). During the past decade, these high current account deficits have been covered by massive inflows of private capital, primarily foreign direct investment (FDI) thanks to unique privatization opportunities, but also portfolio investment and borrowing on international financial markets. A number of EE countries have accumulated very large external debts, rendering debt service excessively dependent on continuous inflows of foreign capital. Gross external debt of Bulgaria, Croatia, Estonia, Hungary, Latvia and Slovenia have already reached 80-130% of their respective GDPs (IMF, 2008). Morgan Stanley estimates that EE has borrowed $1.7 trillion abroad, mainly on short term maturities, and must repay, or roll over, $400 billion this year, equal to a third of the region's GDP (see Evans-Pritchard, 2009). Though this is low with respect to the scale of USA and west European states, with the worsening of the financial crisis there have been increasing fears that one or more EE countries could default on its debt.

Because of their large external financial needs, the EE countries are among the most exposed to the global credit crunch. Forecasts for 2009 indicate a substantial reduction in all forms of private capital inflows to EE and more limited access to external finance. One of the major drivers of growth in EE, FDI inflows, for the EE region as a whole are expected to fall from a record US$ 155 billion in 2008 to US$ 98 billion in 2009 (EIU, 2008, p. 33). Medium-and long-term debt inflows are projected to fall by even more, from US$ 360 billion in 2008 to about US$ 200 billion in 2009. In those CIS countries and the Balkans where remittances have been important, this source of finance is also expected to decline by 10-20% (Kekic, 2008).

2. *Features of the banking system*: The privatization of the banking sector in EE over the last fifteen years has led to a massive sale of assets to foreign banks from EU countries, including Sweden, Denmark, Austria, Italy, Germany, Belgium, France, Greece. Except for Slovenia, in all the other new EU member states and the Balkans, presently 70-98% of banking assets are in foreign ownership. This was considered the best way to create a solid and efficient banking system, given the general lack of resources for a major recapitalization of state banks that were heavily burdened with non-performing loans, and to transfer technology and managerial know-how to EE, thus

facilitating faster convergence to western banking standards. Relying on multinational banks from the EU as their primary source of capital, rather than on international financial markets, was also supposed to protect EE countries from financial crises.

Paradoxically, it is precisely this characteristic – strong foreign banking presence – that renders EE countries (except the CIS region) much more vulnerable to the present financial turmoil. These EE economies today depend excessively on capital funds provided by western parent banks to their eastern subsidiaries. During the last decade subsidiaries of western banks in EE have extended an enormous amount of loans to local clients, especially to households. With the present credit crunch in their countries of origin, not necessarily will these banks be able to continue extending capital to their local clients in EE. Under pressure of the credit crunch, increasing withdrawals of capital and decreased lending in EE are highly likely. According to recent EIU forecasts, in 2009 bank loans in EE are expected to drop to 50% of their level in 2008 (Kekic, 2008). It should also be noted that the risk protection systems in many EE countries are still incomplete, with low ceilings for deposit insurance.

Though the risks of foreign ownership of banks in EE countries have initially been underestimated, based on arguments that withdrawals by foreign banks are unlikely given their high profitability in EE, more recently there have been increasing fears of a serious banking turmoil in eastern Europe and its just as dramatic consequences for western Europe - given that the west and east European banking systems are so closely intertwined. In mid-February 2009 some main credit rating agencies have warned that west European banks with east European subsidiaries were at risk of being downgraded. Several EE countries seem to have already been hit by the rapid withdrawal of foreign capital, with severe consequences for exchange rates of many EE currencies (see Wagstyl, 2009). Depreciation of EE currencies raises the prospect of widespread defaults on foreign currency loans offered by foreign owned banks. Austria's banks seem the most exposed, with east European loans amounting to some 75% of its GDP, followed by Sweden (30%) and Greece (19%) (Wagstyl, 2009).

3. *Trade integration and openness:* Most of the new EU and Balkan countries are already highly integrated into the EU economy through trade flows, the EU representing their main trading partner with a share of around 60-90% of both exports and imports (this is much less so for the CIS countries). In addition, most EE countries (including Russia) are relatively open economies, which renders them highly vulnerable to deteriorating conditions on exports markets. The new EU members, on average, have a higher degree of openness (measured by the exports/GDP ratio) than a number of old EU member states. With the exception of the largest economies - Poland and Romania - all the other new EU countries are much more open than most of the old EU member states (except Belgium, the Netherlands and Luxembourg).

Given that the global financial crisis is having a significantly stronger impact on growth in western Europe than initially anticipated, the EE countries will clearly be badly hit by falling demand for their exports, particularly in view of the severity of the recession forecasted for 2009 in some of the EE countries' main trading partners – Germany, Italy, Austria. This will have serious implications for growth in the EE region. Since last November, all 2009 GDP growth forecasts for EE countries have been continuously and substantially adjusted downwards: the February 2009 forecast of the EIU gives the most dramatic estimate so far, of minus 2% for the whole EE region.

4. Constraints on economic policies

What can the EE governments do in the case of a major banking crisis caused by withdrawals of capital by foreign owned banks? What economic policies can they implement to reduce the

expected impact of the ongoing or forthcoming recession? Contrary to governments in the old EU member states, which have already provided for the coverage of bank losses also through nationalizations, or are ready to intervene with guarantees and emergency loans, governments and central banks in EE are not in a position to easily inject new liquidity into the economic system for a series of reasons.

The new EU member states, including those that are not yet members of the European Monetary Union (EMU), cannot implement large stimulus packages because of their obligations vis-à-vis the EU, as prescribed by the Stability and Growth Pact which imposes strict fiscal discipline - the 3% GDP limit on the public deficit (0% in the course of the cycle), and the 60% GDP limit on public debt. Although most EE countries have a relatively low public debt, Hungary's has reached 65% of its GDP. Even those EE countries that could perhaps afford to run a counter-cyclical expansionary fiscal policy to offset the effects of the recession are constrained by aspirations to soon join the EMU (e.g. Poland).

Regarding monetary policies, in many EE countries these are in the hands of central banks that are even more independent than their inspiring model, the Bundesbank, therefore less sensitive to pressure from their governments. In some cases monetary policies cannot be effective in stimulating growth due to fixed exchange rate regimes, or cannot be used at all due to currency boards (in Estonia, Lithuania, Bulgaria, Bosnia and Herzegovina). Under rigid exchange rate regimes, central banks cannot be lenders of last resort in case of large withdrawals of capital from the banking system. In those EE countries that have flexible or managed float regimes, the global financial crisis has led to the rapid depreciation of their currencies throughout 2008 and increasing currency substitution. In Poland, Romania, Hungary, the Czech Republic, national currencies have steadily depreciated throughout 2008 reaching the lowest point in mid-February 2009 (see Wagstyl, 2009). The recent cut in interest rates in Poland and the Czech Republic has contributed to such trends, increasing panic among households that have mortgages in Swiss francs or euros.

Recommendations

The outlined features of primarily the ten new EU member states and six Balkan countries - high external imbalances, foreign ownership of banks, strong trade dependence on EU markets, more constrained government economic policies – render them particularly vulnerable to the present global financial and economic crisis. For most of the EE countries, the global crisis is an external shock of such dimensions that it will necessarily require substantial external finance for covering large current account deficits, repaying foreign debt, rescuing banks in crisis, sustaining growth and employment. External finance needs to be made more readily available, in substantially larger amounts, and possibly at better terms, not only by the international financial institutions (IFIs) but also by the EU institutions and possibly western governments.

1. Increasing the availability of external finance by international financial institutions

The IMF has already provided, or is presently negotiating, emergency loans with a number of EE countries, including Hungary, Latvia, Ukraine, Kyrgyz Republic, Serbia, Romania, and Belarus. Other international financial organizations, including the World Bank, the European Central Bank (ECB) and the EBRD, have joined the IMF in helping some of the most affected countries. The problem is that the finance needed to rescue some EE countries, but also other emerging markets and low-income countries may be largely insufficient, since the IMF may soon exhaust its available $200 billion reserve. This is why Dominique Strauss-Kahn has announced the intention to double

the Fund's lendable resources, to some $500 billion (IMF, 2009). These efforts should be joined by the other IFIs.[1]

2. Stronger EU-led region-wide action: More active EU support must be urgently provided to the EE region – and for the benefit of the whole of Europe - given that ten EE countries are already EU member states, while the six Balkan countries are EU candidates or potential candidates, economically and financially strongly integrated with other EU member states. Whereas the ECB has already helped a few of the most affected countries, EU institutions and western countries' governments will need to consider providing more coordinated, region-wide support to the EE region. Although presently there are major uncertainties about the amount of bad loans and possible banking losses in EE, a major banking crisis in some EE countries is not to be excluded, which would have far-reaching consequences for the most exposed west European countries. Although in some EU countries demands for support schemes to rescue foreign subsidiaries in EE countries have been gaining ground - Austria is leading a campaign for a region-wide support package - there are other countries that have resisted such demands and the European Commission continues to prefer a country-by-country approach. In February 2009 Robert Zoellick, the president of the World Bank, has called for an EU-led coordinated global support for the economies of central and eastern Europe.

3. Controversial conditionality: The latest agreements concluded by the EE countries with the IMF seem to be based on similar orthodoxy as those in the past, as they all insist on fiscal adjustment programmes – cuts in budget deficits, public sector lay-offs, tight control over public-sector wages, freezing of social transfers (see Manktelow, 2008). Whereas enormous fiscal stimulus packages are being implemented throughout the western world – in the US totalling $780 billion, or 5% of GDP over the next three years (2009-11) - EE countries currently in difficulties are required to do just the contrary. Although it has been argued that EE countries are in a different situation as they cannot afford such packages, clearly there is need for more flexibility and softer conditionality, otherwise the recession in EE is likely to be even more profound than currently anticipated. Similarly, double standards are being used by the EU Commission. Whereas a number of old EMU members have not been respecting their Stability and Growth Pact obligations, binding also for non-EMU members, the new EU member states from EE aspiring to join the eurozone have to demonstrate strict compliance with the Maastricht criteria that are even more rigid (involving interest, inflation, and exchange rate constraints, and no flexibility on the 3% deficit ceiling).

4. World currency: The amount of finance that can be provided to the EE region by the IFIs, EU institutions and EU member states could prove insufficient to substantially help overcome the ongoing crisis. More generally, in view of the global character and unprecedented scale of the current financial and economic crisis, we may be nearing the point where "the IMF may have to print money for the world, using arcane powers to issue Special Drawing Rights" (Evans-Pritchard, 2009). There should be a reconsideration of Special Drawing Rights as a source of counter-cyclical financing, and more permanently, as a global currency for a better globalization (Ffrench-Davis, 2007).

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UN-DESA Policy Brief No. 9

Bubbles, busts, and bailouts: Lessons from the global financial meltdown

What first appeared as sub-prime mortgage cracks in the United States housing market during the summer of 2007, began widening during 2008 into deeper fissures across the global financial landscape, and ended with the collapse of major banking institutions, precipitous falls on stock markets across the world and a credit freeze. These financial shockwaves have now triggered a fully-fledged economic crisis, with most advanced countries already in recession and the outlook for emerging and other developing economies deteriorating rapidly, even for those with a recent history of strong economic performance.

The cost of the government response in the United States (in the form of liquidity injections, credit warranties, bail-outs and stimulus measures) has risen steadily over the past year to more than $7 trillion by November 2008, and together with the combined measures of European countries and elsewhere the count may well be in the order of $11 trillion (more than 20 per cent of world gross product).[1] Emerging markets are also beginning to respond, notably the recent major fiscal stimulus packages announced by China and the Republic of Korea. Along with mergers and acquisitions (including by the public sector itself) such moves have radically altered the financial landscape and buried the myth of efficient and self-regulating financial markets. Even so, rebuilding confidence and stopping the downside spiral is proving difficult as jobs are lost, exports contract and consumer and investor confidence continue to head south.

This policy brief looks at how this happened and what needs to be done to regain stability and jumpstart a sustainable global recovery.

A once in a century event?

After presiding over one of the largest bubble economies in modern economic history, former Federal Reserve Chair Alan Greenspan has recently described the current crisis as a once in a century event. Even if this is correct, as now seems likely, in terms of its severity, it is highly misleading as a description of the underlying pattern of events. Manias, panics and crashes have been recurrent throughout the history of the modern financial system, sometimes threatening near systemic failure, such as the developing country debt crisis of the 1980s and the Asian financial crisis in the late 1990s. Each boom-bust cycle has its own idiosyncratic features, but they all exhibit certain common characteristics. They are triggered by new high-yielding financial investment opportunities which are supported by increasing credit. Asset price bubbles emerge, fomented by euphoric speculation and widening leverage ratios. As more and more purchases are made on margin or by instalments, the resilience of borrowers to downside risks is weakened, giving rise to financial distress and a rush for liquidity as soon as prices begin to fall and expectations go in to reverse. The frequency of these cycles and the damage they cause tend, moreover, to be greater following a period of rapid market deregulation and liberalization. Just such a trend began in advanced countries in the late 1970s, accelerating from the early 1980s and spreading, thereafter, to many developing countries.

From sub-prime borrowers to submerging economies: who is to blame?

A good deal of analysis has focused on stresses in the housing market, particularly in the United States, where so-called "sub-prime" mortgages and home equity loans helped feed a $15 trillion home mortgage debt mountain. The collapse of the real estate market has led to defaults and foreclosures and a good deal of personal hardship. However, this is rather a symptom than a cause of the problem. The 15-20 per cent drop in (average) US house prices since their peak in 2006 could not, by itself, have triggered a global financial meltdown. That is, rather, the direct result of an incessant drive to deregulate markets—dismantling firewalls within and across the financial sector—and the promise that efficiency gains and higher profits would be accompanied by a more secure investment climate thanks to product innovations and the self-discipline of market participants. In the United States and elsewhere, this has led to the eclipse of traditional deposit and insurance institutions, which accounted for over two thirds of financial sector assets in the United States in 1976 but only 30 per cent

1 The estimates refer to committed funds either in the form of guarantees on loans and deposits, direct government investments in financial institutions, low interest-rate loans made by governments as part of bailouts and fiscal stimulus. Such committed funds by the United States government amassed $7 trillion to November 2008 and of which about $1.4 trillion had been effectively spent by that time. Alongside, the EU and the United Kingdom had set aside some $3 trillion in financial bailout resources and fiscal stimulus, and an estimated $1 trillion by China and other countries.

in 2006, by a new breed of financial enterprises (and speculators), including hedge funds, mutual funds, and security brokers and dealers. These players have introduced a plethora of new financial instruments (mortgage backed securities, collateralized debt obligations, credit derivatives and swaps, etc) for leveraging credit and managing risk, and which encouraged mounting levels of debt in the household, corporate and public sectors. In some countries, both developed and developing, domestic financial debt as a share of GDP has risen four or five fold since the early 1980s. Much of this growth was allowed to happen outside of the reach of regulators and regulatory frameworks. As the boom continued the talk was about how everyone was winning while the risks were conveniently ignored, despite the warning signs that mounting household, public sector and financial sector indebtedness in the United States and elsewhere could not be sustainable over time.

The logic of unregulated finance has, moreover, taken charge of the globalization process which, in the absence of international checks and balances, has introduced a further source of fragility as financial institutions have expanded their cross-border operations in search of the next boom cycle. The hypertrophying of the Icelandic financial sector to many times the size of its national GDP is a particularly exaggerated example of this broader trend.

What makes this a systemic crisis?

This crisis is systemic because its origins lie within the workings of financial markets themselves; and it has affected all financial institutions simultaneously, freezing the supply of credit with a devastating effect on the real economy. Credit is an essential part of any economy where decisions take time to come to fruition and managing credit risk is a necessary part of a healthy economy. However, the greater the distance between those that first arrange a loan and those holding the risk, the greater the number and diversity of creditors to any individual borrower, and the greater the capacity to actively trade credit risk, the greater the danger that risks will go undetected or be under-priced. Alarm bells should have sounded, when the value of the securities involved in financial transactions reached several times global income, and as these transactions were 'sustained' through leverage ratios (the proportion of debt acquired on the back of each institutions own assets) of 30 or higher, as compared with the ceiling of 10 normally imposed on banks. Furthermore, the increasing complexity of credit derivatives led to excessive reliance on rating agencies who proved inadequate to the task at hand, in part because of conflicts of interest over their own sources of earnings which are proportional to the trade volume of the instruments they rate.

The spread of financial networks across the world, and the vested belief that securitization could effectively conquer risks, has made practically all financial transactions hinge on the 'confidence' that each counter-party in isolation is capable of backing-up its operations. This seems an elusive assumption when asset prices are rising across the board. Indeed, as prices start to fall and insolvencies emerge, such confidence is weakened, and may quickly vanish generating a credit freeze which spreads to the business sector, and which in turn makes them increasingly vulnerable. Because the underlying assets have been valued and their risk assessed by the originating financial institution, a turnaround can very quickly drain trust from the entire system.

Whatever happened to the "goldilocks economy"?

The advocates of efficient financial markets promised lasting prosperity and stability so long as political interference was kept to a minimum and macroeconomic policies stuck to keeping a tight reign on inflationary pressures. Such phrases as the "goldilocks economy", the "great stability" and the "great moderation" rolled around policy making circles and the financial press as the boom began to take hold giving the impression that a new era of macroeconomic tranquillity and unbounded prosperity had arrived. In reality, with asset prices conveniently left out of inflation-targeting models, macro policy was overseeing a debt-driven boom in which asset prices rather than income flows determined spending decisions and attitudes to risk, and where investment became identified with rearranging existing assets through leveraged buyouts, stock buybacks and mergers and acquisitions. By overlooking more traditional concerns -- such as the level and composition of aggregate demand, labour market performance, etc -- the policy choices and institutional reforms deemed necessary to bolster market fundamentals have ended up weakening long-term growth and stability. Sluggish employment growth, stagnant wages and anaemic investment in productive capacity, in both the private and public sectors, were among the clearest signs that this policy stance was failing to deliver in many countries, both developed and developing, even as "boom" conditions prevailed.

What has the financial crisis to do with 'global imbalances'?

The present crisis comes on top of a prolonged period of growing financial and macroeconomic imbalances which originated in the early 1990s as the United States became the global consumer of last resort. Domestic savings all but evaporated and ever widening trade and current account deficits were chalked up. The deficits were financed by capital inflows from surplus economies whose own performance depended, in no small part, on selling goods to (increasingly indebted) consumers in the United States. For this to continue, indebted

countries depended on rising asset (and currency) values to attract foreign investors, while creditor countries' were expected to maintain low costs of production by postponing wage increases and higher social expenditures to ensure overseas demand for their exports. This nexus provided the basis for massive international leveraging by financial institutions. The years between the Asian financial crisis in 1997 and the bursting of the 'dot-com' bubble in 2000, set the stage for a further twist in the interconnected tale of macro imbalances and deregulated finance, as emerging markets accumulated massive reserves to insure themselves against future shocks by increasing production, curtailing domestic spending and exporting, and the United states (and a few other advanced countries) specialized in creating attractive asset markets by (successfully) building the expectation of ever-rising values (initially in stock markets). The loosening of monetary policy in the United States in response to the dot.com bust was the catalyst for an even bigger explosion in lending by financial institutions, frantically, searching for higher and higher returns at home and abroad.

Have we hit bottom?

As long as confidence is not restored, the financial system will continue to malfunction; financial investors will focus on repairing their balance sheets by liquidating assets, inducing further price falls; and productive investors will retreat in the face of reluctant consumers at home and abroad, further choking demand. An important step in restoring confidence comes with the perception that policy makers will do 'whatever it takes' to turn the crisis around. Some big steps have been taken to repair the financial system and bolster demand but doubts and ambiguities remain over the value of the 'toxic' assets being acquired, whether or not recapitalizing the financial institutions will activate the flow of credit and help the resumption of economic activity and whether or not tax payers will have to carry most of the costs of the bail outs. As time passes, the real economy weakens further, triggering a new round of threats to financial stability and raising doubts about the speed of any recovery.

Given the systemic nature of the crisis, the domestic measures which can help restore balance sheets, rekindle animal spirits and strengthen consumer confidence must not only be commensurate with the scale of the problem but must also be co-ordinated worldwide. This has not happened yet. If confidence is not quickly restored, the United Nations projects in the latest World Economic Situation and Prospects 2009 (http://www.un.org/esa/policy/wess/wesp.html) that the world economy would continue to slip deeper in to recession, reaching a global growth rate of only 1 per cent per annum in 2009 with no strong recovery likely to follow any time soon.

What will be the impact on developing countries?

Beginning with the debt crisis of the early 1980s, developing countries have been on the fault line of the new financial architecture, enduring a series of recurring financial crises through the end of the 1990s. However, a period of widely shared and strong growth from 2001 raised hopes that the developing world had become much less vulnerable to external shocks and had accumulated sufficient reserves to manage any downside risks. Moreover, there was a growing belief that this growth would provide a way to correct global imbalances and even provide a safe haven from financial turmoil elsewhere. This so-called "decoupling" thesis ignored the fact that global imbalances were organically linked to the unprecedented debt explosion in deficit countries and that favourable global demand was dependent on the pace and volume of imports from advanced countries.

In reality, developing countries are already being hurt by the crisis through international trade and finance channels. Commodity prices have dropped significantly since their peaks in the summer hurting primary exporters in particular, but lower developed country demand will affect export growth throughout the developing world. Some emerging market economies, such as Brazil, are already facing severe curtailments in access to trade credits and the threat of reversals in private capital flows.

A rapid reversal of capital flows together with the rising cost of borrowing and asset price deflation has already hit some emerging markets, particularly those which still hold large stocks of external debt, driving some back to borrowing from the international financial institutions. But even the vast amounts of foreign reserves accumulated by developing countries in recent years may quickly evaporate in the ensuing global crisis.

There is also the risk that aid commitments to the poorest countries will be drastically curtailed as fiscal priorities change in the wake of bank bail outs and rising deficits in the donor countries. Moreover, the flow of worker remittances, an increasingly important source of foreign exchange for some countries, is certain to slow sharply as employment prospects falter in more advanced economies.

A growing number of developing countries have already witnessed a significant deceleration in economic growth. Even if the contagion were mostly confined to trade flows, developing countries as a whole would see growth rates drop to 4.6 per cent in 2009, compared to 6.7 per cent over the last three years. But considering the wider threats from the financial crisis, growth may drop to well under 3 per cent, with some regions, like North Africa and Central America (including Mexico) falling into outright recession, and others like sub-

Saharan Africa and South America experiencing growth rates under 1 per cent, far below their population growth.

All this, no doubt, is diminishing the prospects of achieving the MDGs.

What should a global new deal involve?

While this is the first synchronised global slowdown since the 1930s, it is unlikely that this time around a deepening global recession will collapse in to global depression. Rather, it seems more plausible (and certainly more hopeful) that policy makers around the world decide to act, sooner rather than later, in a co-ordinated fashion and with full awareness of the gravity of the crisis in financial markets and its relation to global imbalances, as well as with a sensitivity to wider economic goals and the political ramifications of their actions on each other.

What is required is a new global deal which centres on employment creation as much as it does on reviving the financial system, and includes reform of the international economic system so that it can support a more balanced integration of all countries, but particularly developing countries, into the global economy.

One encouraging feature of the response to the crisis (and very much in the spirit the original new deal) has been the way in which policy makers in rich countries have been willing to experiment with a variety of measures, whether loosening macroeconomic policy, nationalization, subsidies, capital controls, previously excluded from the policy tool kit on ideological grounds.

The first challenge remains to restore confidence and stability in the financial system. However, bailouts and liquidity injections will not be sufficient if there is little prospect of economic recovery. The scope for a further monetary stimulus has become very limited, especially in the United States where interest rates on Treasury Bills are near zero and a liquidity trap is looming. A substantial fiscal stimulus therefore will be needed to give new impetus to faltering economies. Both developed and developing countries are now considering these, but given the scale and the depth of the crisis only massive packages can expect to make sufficient difference. China's package, totalling $586 billion (or 15 per cent of its GDP) to be spent over the next two years, might be up to the challenge. However, the global economy may only see sufficient benefit if the fiscal stimulus is provided in an internationally coordinated fashion. In a globalized economy, fiscal stimulus in a single country can be undercut by import leakage and other such effects; when internationally coordinated, a reinforcing multiplier effect can take hold.

Such a crisis response could provide a unique opportunity to serve broader global goals by aligning the fiscal stimuli with much-needed investments in long-term sustainable development. The massive resources required to reactivate the global economy can be applied in part to public investments in infrastructure, food production, education and health and renewable energy sources, helping developing countries to diversify their economies and meet the Millennium Development Goals.

The second challenge is to address the systemic flaws of the international financial architecture in order to prevent the kind of problems the world is facing today from happening again. Detailed reform blueprints can only emerge through full and open discussions which include all interested parties, but some key issues have already surfaced:

- Establishing a credible and effective mechanism for international policy coordination. To guide a more inclusive process this not only requires participation of major developing countries, but also more representative institutions of global governance and hence a fundamental revision of the governance structure and functions of the IMF and the World Bank.
- Fundamental reforms of existing systems of financial regulation and supervision leading to a new internationally coordinated framework that can stem the excesses of the past.
- Reform of the present international reserve system, away from the almost exclusive reliance on the US dollar and towards a multilaterally backed multi-currency system which, perhaps, over time could evolve into single, world currency backed system.
- Reforms of liquidity provisioning and compensatory financing mechanisms, backed, among others, through better multilateral and regional pooling of national foreign exchange reserves and which avoid onerous policy conditionality attached to existing mechanisms.

Such reforms will not easily find consensus among all stakeholders, but the risk of endangering global peace and prosperity by failing to address the systemic problems underlying the present crisis are simply too high and this awareness should give the impetus to finding common solutions. ■

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Monthly Briefing on the World Economic Situation and Prospects

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Summary

- The impact of the financial crisis on economic activity has intensified worldwide.
- Industrial production and international trade flows have declined sharply, and unemployment is rapidly rising globally.
- Countries need to move more swiftly to forceful and globally coordinated policy actions to prevent the financial crisis from turning into a large-scale economic and social crisis.

Global issues

Considerable, globally coordinated fiscal stimulus is urgently needed to fight off a global depression

The world economy has begun 2009 on a grim note. The major developed economies had already fallen into a deep recession, while developing countries are now also experiencing a dramatic downturn. After tens of trillions of dollars of financial wealth have evaporated, the global financial crisis has also begun to take a tremendous toll on human capital. Unemployment rates are rising at an alarming pace worldwide and many more job losses are expected to follow in the coming months. As a result of the demand retrenchment in the major developed countries, global industrial production and trade have fallen precipitously in recent months, sharply dragging down growth in many developing countries with the accompanying risk of rising poverty rates.

Financial markets remain under great strains worldwide. The balance sheets of major financial institutions continue to deteriorate and credit markets remain clogged. More seriously, a vicious interaction between the financial crisis and the economic recession is forming. In order to avert another Great Depression, policymakers worldwide need to act swiftly to adopt considerable fiscal stimulus packages in an internationally concerted manner. A number of countries have announced fiscal stimuli (see table 1), but the size of the stimulus packages may not be large enough to deal with the scale of the crisis. The packages so far would amount to more than 3 per cent of World Gross Product, but are to be spent in most cases over a number of years, making the likely impulse much smaller than what many see as required. Meanwhile, as there is a lack of international coordination for these packages, the effectiveness of these policies remains uncertain. Hesitation also remains in some countries in view of major concerns regarding the possible negative repercussions in the longer run from widening fiscal deficits, which are already ballooning in some countries as a result of the financial crisis. While such concerns are legitimate, the benefits of these stimulus packages, when effectively coordinated, should outweigh the economic and social costs of the prolonged and deep global recession that would most likely be the consequence of inaction.

Many agencies have downgraded their forecasts for 2009, including the International Monetary Fund (IMF), which trimmed its growth projection for the world economy in 2009 by 1.7 percentage points from its forecast of November 2008.

Note to the Secretary-General prepared by the Global Economic Monitoring Unit
Development Policy and Analysis Division, Department of Economic and Social Affairs
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Table 1. Fiscal stimulus (announced)

Country	GDP (percentage)	Value (billion US dollars)
Australia	4.0	36.4
Brazil	0.2	2.6
Bulgaria	0.8	0.3
Canada	2.0	28.7
Chile	2.8	4.6
China	15.0	586.0
Czech Republic	0.4	0.7
Egypt	0.3	0.4
France	1.5	38.9
Germany	3.1	102.9
India	1.3	14.3
Indonesia	1.5	6.5
Italy	4.3	90.5
Japan	2.0	87.6
Korea, Republic of	1.0	9.7
Malaysia	1.0	1.9
Mexico	0.7	7.2
New Zealand	4.0	5.1
Philippines	4.0	5.8
Russian Federation	1.1	14.2
Singapore	8.2	13.2
Slovenia	1.4	0.6
Taiwan Province of China	1.7	6.5
Thailand	1.7	4.2
United Kingdom	1.1	30.8
United States	5.8	800.0
Viet Nam	1.1	0.8
Total		**1900.5**

Sources: Announcement by individual countries.

Note: The definition and the contents of the policy measures vary from country to country, and some are for one year while others for a span of several years. The size of these packages may not be comparable across countries.

in increased inventories and the stabilization of crude prices within the range of $40-45 pb. OPEC's announcements in the fourth quarter of 2008 to cut production by a total of 4.2 million barrels per day and a relatively high compliance rate by member countries have also contributed to the stabilization at the present price level. Thus far, however, the measure has not had the intended effect of reversing the price decline and raising the oil price to levels needed by many OPEC countries to balance their fiscal budgets.

Developed economies

United States: collapsing growth, employment and housing market activity have led to further policy action

The United States economy shrank at an annualized rate of 3.8 per cent in the fourth quarter of 2008. The decline was mainly caused by the stark reduction in personal consumption and fixed investment. Increases in inventories and larger government spending partly compensated for the decline in private sector demand, but without preventing the drop in GDP. In addition, net exports came to a complete halt, after having been an important contributor to GDP growth during the previous 18 months.

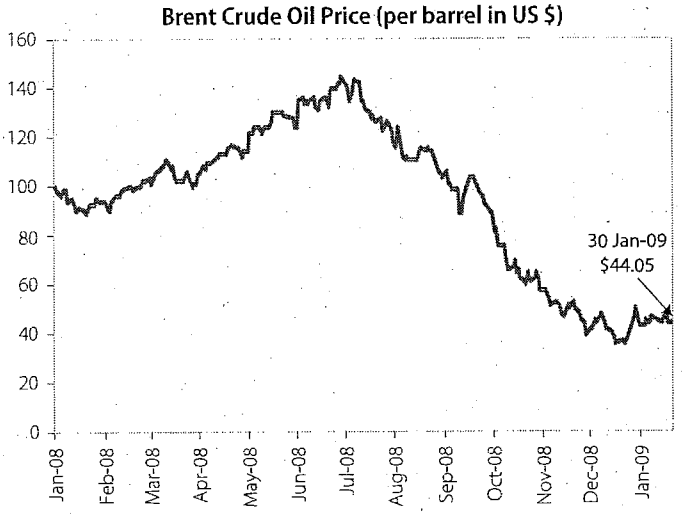
International trade is contracting, while protectionism is on the rise

At the end of 2008, international trade activity had shrunk significantly. In November 2008, the value of total world trade was about 14 per cent lower than in November 2007. Besides the decline in prices for traded goods, this contraction mainly reflects reduced demand from developed economies. The shortage of trade credit caused by the global credit crunch was also conducive to the contraction and is hurting developing countries in particular. Financial rescue operations should consider measures that will unclog trade credit flows, including through guarantees.

Over the last months, more than 20 developed and developing countries have adopted measures to protect their domestic industries, especially through export subsidies, import restrictions or higher tariffs and non-tariff barriers. Meanwhile, unilateral interventions leading to currency depreciations have been a growing concern as they have the same effect as protectionist measures. This has led to calls for more elaborate coordination among countries to avoid the negative-sum-game that protectionism implies.

Oil prices traded sideways

Brent crude oil prices rose from $34.68 per barrel (pb) to $48.76 pb at the beginning of January 2009 owing to cold weather, uncertainty related to the gas dispute between Russia and Ukraine and the military conflict in Gaza. However, because of ever bleaker economic prospects in the major economies, global demand for crude oil continued to fall, resulting



About 3 million workers lost their jobs during 2008 and the pace of job losses has accelerated dramatically over the past few months. In the fourth quarter of 2008, non-farm payrolls showed the largest quarterly decline since 1945, with the unemployment rate rising to 7.2 per cent by the end of 2008.

The housing slump continues. New-home sales fell 14.7 per cent in December, with the median price plunging by more than 9 per cent from the previous year. While the inventory of unsold new homes fell 10 per cent from November, it is still equivalent to 12.9 months of sales. Meanwhile, starts of new housing projects declined nearly 70 per cent in the fourth quarter of 2008, despite the notable decline in mortgage interest rates since the Federal Reserve announced in late November it would buy up to $500 billion in mortgage-backed securities to get banks to lend more money in the hope of bolstering the troubled housing market. Further measures are expected to be adopted this month in an attempt to put more pressure on financial institutions to resume lending.

The House of Representatives of the United States Congress passed the American Recovery and Reinvestment Act worth $819 billion to jump-start the economy. The package was also approved by the United States Senate after several amendments. The package includes tax cuts for middle-income families and spending in areas such as clean and more efficient energy, science and technology, health care, education, infrastructure and employment services.

Canada: fiscal stimulus accompanies further loosening of monetary policy

The Bank of Canada cut its key overnight interest rate by 50 basis points (bp) to 1 per cent. In parallel, Canada's government unveiled a stimulus package worth $32 billion over five years that includes infrastructure spending and tax cuts. The government predicts that the plan will boost the economy by 1.4 per cent this year and create 190,000 jobs by 2011, after the country lost more than 100,000 jobs in the last two months of 2008.

Western Europe and the EU: deteriorating economic conditions have led to further stimulus measures

In Western Europe, the economic situation remains precarious. In the UK, for example, GDP contracted by 1.5 per cent in the fourth quarter, the sharpest decline since 1980. Survey data for January indicate a further contraction of activity going forward, although the indices were slightly more stable than in previous months, which had been characterized by sharp drops in readings.

After a long period of improvement, unemployment rates are rising across the region, with euro-area unemployment now standing at 7.8 per cent. Spain has been especially hard hit, with its economy moving officially into recession and the unemployment rate jumping from a cyclical low of 8.0 per cent in April and May 2007 to 13.4 per cent in January 2009.

Against the backdrop of falling inflation, central banks in the region continued to ease policy. The European Central Bank lowered its policy rate by 50 bp, bringing it to a level of 2.0 per cent. The Bank of England also lowered its policy rate by 50 bp, to 1.5 per cent.

On the fiscal side, the German government announced a second fiscal stimulus package worth 50 billion euros for 2009 and 2010, which will be in addition to a plan worth 32 billion euros that was announced two months ago, bringing the total stimulus to about 3 per cent of GDP. To date, France has announced stimulus worth 1.5 per cent of GDP, Italy 4.3 per cent of GDP and Britain 1.1 per cent of GDP. In comparison, the US stimulus is 5.8 per cent of GDP.

Amid continuing volatility in the currency markets, the dollar rebounded from relative lows above $1.40 against the euro at the beginning of January to reach $1.28 at the end of the month, while against the Yen, after a brief upward move to ¥94, it lost ground and returned to the ¥88-90 range.

The new EU member states: policy makers face constraints in addressing the economic downturn

Economic activity in the new EU member states continued to weaken. Output growth slowed sharply in Central Europe and was in negative territory in the Baltic States, with GDP declining by 10.5 per cent in Latvia in the fourth quarter of 2008, for instance, while industrial production declined in most parts of the region, including Poland, which is less dependent on exports to the EU-15.

To counteract the crisis, a number of governments drafted fiscal stimulus packages, although the room for fiscal maneuvering is limited given the budget shortfalls due to the economic slowdown. A number of central banks, such as those

of Hungary and Poland, reduced interest rates in January in order to restore credit flows in the economy.

The region was seriously affected in January by the gas dispute between Russia and Ukraine, which interrupted industrial production at large-scale manufacturing facilities.

At the beginning of the year, Slovakia joined the euro zone.

Japan: economic indicators are worsening, with the return of deflation looming

Japan is facing a further deterioration in economic activity and entered its third quarter of recession. New economic indicators were worse than expected. Weakening external demand and the appreciation of the yen continue to affect exports, in particular in the automobile and electronic sector. In December, Japanese industrial production fell by 9.6 per cent month-on-month, while private consumption weakened by 4.6 per cent. Unemployment climbed at the fastest monthly rate over the last 41 years to reach 4.4 per cent in December and could go up to 5.5 per cent over the next months.

All these negative indicators led the Bank of Japan to review downward its forecasts: deflation is expected to return as prices should fall by 1.1 per cent during the fiscal year of 2009-10 and 0.4 per cent in fiscal 2010-11, while GDP is now expected to contract by 1.8 per cent in 2008-09 and by 2.0 per cent in 2009-10.

The Japanese government stepped up its efforts to combat the credit crisis by setting aside 1,500 billion yen ($16.9 billion) in public funds to encourage banks to buy shares in cash-strapped companies. Meanwhile, the Japanese parliament adopted a budgetary supplement of 4,790 billion yen ($53.1 billion) to finance new stimulus measures which include the provision of cash to households. However, since the central bank's interest rate target is already 0.1 per cent and public investments remain sluggish due to tight fiscal conditions, the ongoing recession is likely to last over the next year at least.

Australia and New Zealand see reduction in policy interest rates

As a response to the decline in exports and the downward revision of inflation expectations, the Reserve Bank of Australia decided to reduce the cash rate by 100 bp to 3.25 per cent and the Reserve Bank of New Zealand lowered its benchmark official cash rate by another 150 bp to 3.5 per cent.

The economies in transition

CIS: contracting economic activity and falling exchange rates have triggered further policy actions

Economic activity in the Commonwealth of Independent States (CIS) continued to deteriorate, causing a downward revision to the forecasts for 2009 GDP growth in many countries. Given the sharp declines in economic activity across the region and the continued credit crunch at the beginning of 2009, unemployment, wage arrears and short-term employment arrangements have increased across some countries. Business investment has significantly slowed in light of tight credit conditions and growing uncertainties both in the domestic and international markets. By contrast, consumption remained still resilient, underpinned by real wage growth in the public sector in a number of countries.

In the Russian Federation, the government has responded to the deteriorating labour market by increasing the monthly unemployment benefits starting 2009 and by expanding active labour market policies, such as regional programmes to create jobs and assistance with job searches.

The currencies in much of the CIS have depreciated and some central banks have made attempts to smooth the devaluation pressure. The central bank of the Russian Federation has widened the trading band of the rouble against a basket of currencies over 20 times since early November in order to help the country accommodate a gradual devaluation of the currency. As a result, the rouble lost about 19 per cent of its value against the dollar and about 22 per cent against the euro. In Ukraine, the central bank moved to a flexible exchange rate policy after an initial re-pegging of the currency. The value of the currency has experienced a precipitous decline as the country continues to suffer from a large terms-of-trade shock and a deep credit crisis.

Belarus received $2.46 billion in balance-of-payments support from the IMF in order to mitigate the adverse effects of the global downturn on its economy.

South-Eastern Europe: weaker output growth is compounded by fewer remittances

In most of the region, output growth and inflation continue to decline. The region is also facing a decline in remittances. The interruption in the flow of Russian natural gas in January forced some countries such as Serbia to purchase emergency gas supplies and to halt production at many companies.

In Serbia, the central bank reversed its monetary policy stance in January by reducing interest rates in response to weakening output growth and slowing inflation.

Developing economies

Africa: suffering from a downturn in mining and tourism

Africa's growth continues to weaken as the impact of the global slowdown deepens. The mining sector has taken a considerable hit as global demand for metals has waned and prices have plunged. A sharp contraction in South Africa's mining sector contributed to a slowing of annualized growth for the economy to 0.2 per cent in the third quarter and a slight upward tick in unemployment to 23.2 per cent. Mining companies have released thousands of workers and fourth-quarter estimates suggest that South Africa's economy may already be in recession. In the Democratic Republic of Congo (DRC) and Zambia, two other important mining exporters in Africa, there has been a significant drop in revenues from oil, diamonds, copper and other metals, with many new projects being either delayed or abandoned altogether. This has impacted on an important source of tax revenue for these countries and is threatening an untold number of jobs in the sector. In an effort to halt the rapidly deteriorating situation, the DRC is currently seeking a $200 million emergency loan under the IMF's External Shock Facility for low-income countries.

Tourism, another prominent sector for many African economies, is also undergoing a significant downturn. In Tanzania, tourism receipts, which were already down 18 per cent in 2008, are expected to see more significant declines in 2009, while in Egypt, weakened tourism, coupled with lower investment and Suez Canal receipts (which represent 3 per cent of GDP), prompted the country to revise its growth forecasts downwards to 5.2 per cent for the first half of 2009. To shore up the industrial sector and maintain employment, the Egyptian government recently announced a LE 15 billion package ($2.73 billion) for the fiscal year ending June 2009.

East Asia: governments fight accelerating economic crisis

As economic conditions in East Asia continue to deteriorate rapidly, governments and central banks across the region have announced a series of measures to cushion the economic downturn. Recent data show sharp declines in exports and slowing domestic consumption and investment spending, indicating that East Asia will experience a deeper and probably more prolonged crisis than previously expected. Strongly export-oriented economies such as Hong Kong Special Administrative Region of China, the Republic of Korea, Singapore and Taiwan Province of China are most severely hit by the crisis and face severe contractions of economic activity.

China reported a significant deceleration in its GDP growth, which fell to 6.8 per cent year-on-year in the fourth quarter of 2008, compared to growth of 13 per cent for 2007 as a whole. A sharp decline in external demand has been the major drag as exports fell by double-digits year-on-year by the end of the year, which led to a drop in industrial production. On the other hand, there were some tentative signs of stabilization of the domestic economy in December, including stabilizing property markets, in the light of sizable fiscal stimuli and aggressive monetary easing.

Unemployment has started to rise in several countries, with 20 million migrant workers from the countryside reported to have lost their jobs in China alone, raising concerns over the social consequences of the crisis. Against the backdrop of rapidly worsening economic conditions and slowing inflation, many central banks in the region, including those of Indonesia, Malaysia, the Philippines, Thailand and Viet Nam, further lowered their benchmark interest rates. At the same time, the governments of China, Indonesia, the Republic of Korea, Singapore and Taiwan Province of China announced large fiscal packages to stimulate demand, support the business sector and alleviate the social impact of the crisis. China's $586 billion stimulus package, which was announced in November, consists of tax cuts and additional government spending on a wide range of projects, including construction of low-income housing and transportation systems as well as

the development of rural infrastructure. Singapore's government unveiled an ambitious stimulus package, which includes additional spending of approximately $13.6 billion (or about 8 per cent of its GDP).

South Asia: less reliance on exports will cushion the effect of the crisis

While economic growth in South Asia is slowing, the downturn is expected to be less severe than in other developing regions. Exports account for a relatively small share of GDP and domestic demand is forecast to hold up reasonably well in most countries. Yet, there are new signs of weakening economic activity. In October and November, India's merchandise exports contracted and growth in industrial output decelerated markedly. In addition, the service sector is suffering from the largest corporate fraud in the country's history. India's government has responded to the deteriorating economic conditions by announcing two fiscal stimulus packages. At the same time, India's central bank further reduced its key interest rate. In Pakistan, the agreement with the IMF on a $7.6 billion emergency package in November led to an increase in foreign currency reserves. However, with exports falling and the government facing the need to reduce the fiscal deficit, the country's economic prospects for 2009 remain bleak.

Western Asia: lower oil prices put pressure on fiscal balances

At the annual summit meeting of the Gulf Cooperation Council (GCC), member states reiterated their intention to create a monetary union at the beginning of 2010 and agreed on an institutional framework as well as the regulations applying to the monetary council, which will be the precursor of a common central bank.

As a further sign of the pressure on fiscal budgets caused by the fall in oil prices, Oman announced that an average oil price of less than $45 pb would necessitate a revision of its budget and a cut in public spending projects. In addition, Moody's cut its outlook on Bahrain's sovereign rating from stable to negative, citing the recent fall in oil prices and the limited financial reserves available to cushion the negarive effects of the oil-price drop.

Monetary policy was further loosened in several countries. Turkey's slowing economy, as illustrated by a decline in industrial production by 13.9 per cent year-on-year in November due to weaker exports as well as slowing domestic consumption, and expectations of a further fall in inflation from 10.1 per cent year-on-year in December underpinned a cut in the country's policy interest rate by 200 bp to 13.0 per cent. Similarly, Israel's central bank announced a reduction in its policy interest rate by 75 bp to 1.0 per cent, bringing the aggregate cut in interest rates to 325 bp since September of last year.

Latin America: falling output is feeding a rise in unemployment

Economic activity in Latin America is deteriorating more quickly than expected. In Brazil, Mexico and Colombia, industrial output fell by 6.2 per cent, 5.4 per cent and 13.3 per cent respectively year-on-year in November 2008, the worst decline since 1999 for Brazil and Colombia. The factors leading to this serious slowdown are not only the dramatic deceleration of external demand, but also increased restraints on trade credits, a reversal in capital flows and a significant slowdown in domestic demand.

As a result, job losses are increasing rapidly, especially in the manufacturing sector. In Mexico, unemployment stood at 4.3 per cent in December, the highest since 2000. In Brazil, the Ministry of Labour recorded a net job loss of 654,000 in the formal sector during December 2008, the highest since 1999.

Central banks and governments announced counter-cyclical measures to revitalize the economy. Monetary policy easing has become more aggressive in countries like Brazil and Chile, with benchmark interest rates cut by 1 percentage point, to 12.75 per cent and 7.25 per cent, respectively. In Mexico, the benchmark interest rate was cut by 50 bp to 7.75 per cent. However, inflation remains high in countries like Venezuela, Bolivarian Republic of (31 per cent in 2008), Guatemala (9.4 per cent in 2008) and Uruguay (9.2 per cent in 2008), whose central bank decided to increase this month its interest rate by 2.25 percentage points to 10 per cent.

On the fiscal side, a large number of governments announced plans for additional public spending to stimulate the economy. However, several countries face severe financing constraints regarding any stimulus measures. In support, the World Bank approved loans to some countries in Central America and the Caribbean, for example a $450 million loan for El Salvador and a loan worth $100 million for Jamaica.