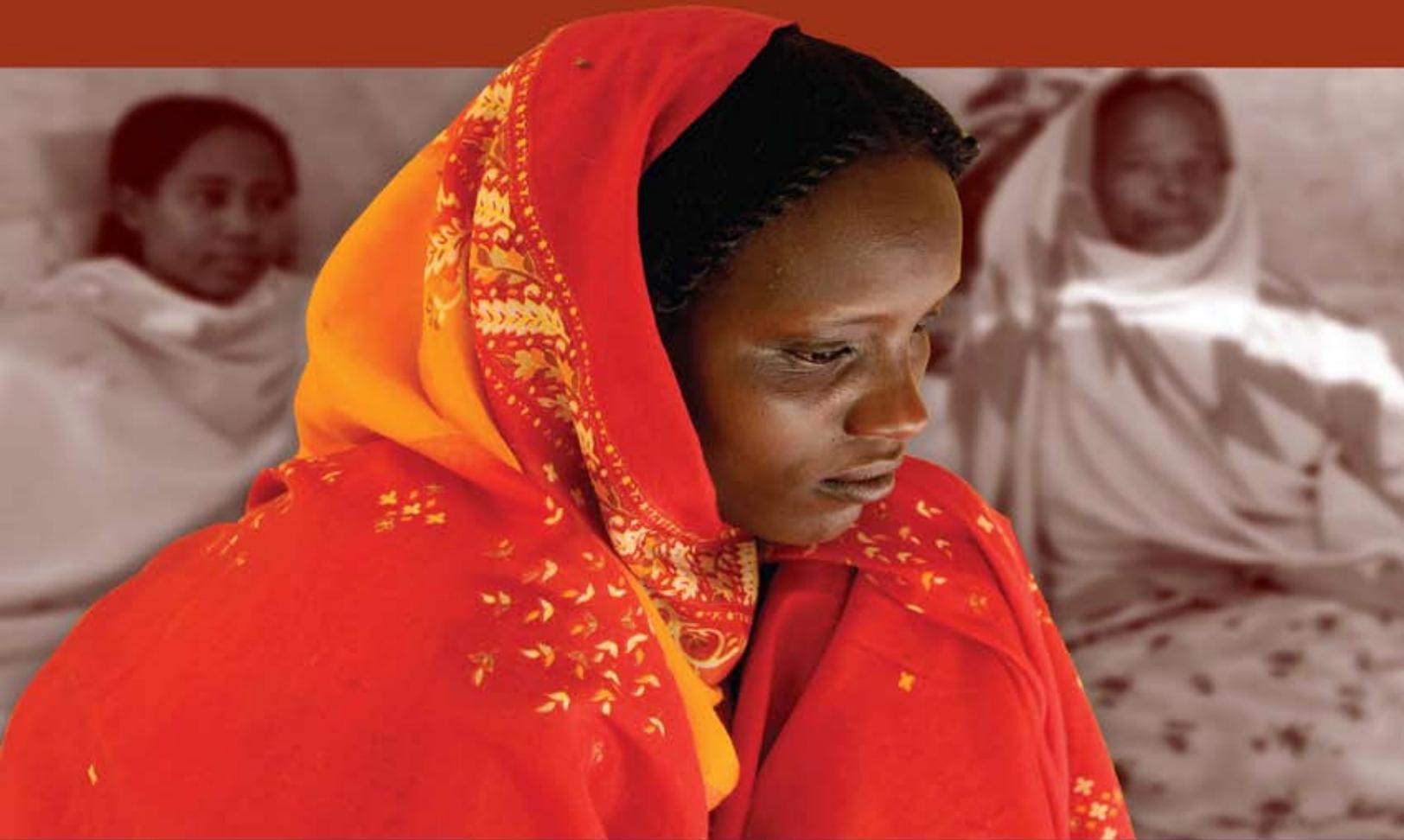


Achieving the Global Public Health Agenda



DIALOGUES AT THE ECONOMIC AND SOCIAL COUNCIL



United Nations

Department of Economic and Social Affairs
Office for ECOSOC Support and Coordination

Achieving the Global Public Health Agenda

Dialogues at the
Economic and Social Council



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NOTE

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Caption photo front cover:

Patients wait for treatment at hospital in Sudan

Three young women patients wait for check-in for treatment, under a tent in the compound of the Fistula Unit of Zalingei hospital in Sudan.

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For further information please contact:

United Nations
Department of Economic and Social Affairs
Office for ECOSOC Support and Coordination
1 United Nations Plaza, Room DC1-1428
New York, N.Y. 10017, USA.

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DESA

The Department of Economic and Social Affairs of the United Nations Secretariat is a vital interface between global policies in the economic, social and environmental spheres and national action. The Department works in three main interlinked areas: (i) it compiles, generates and analyses a wide range of economic, social and environmental data and information on which States Members of the United Nations draw to review common problems and to take stock of policy options; (ii) it facilitates the negotiations of Member States in many intergovernmental bodies on joint courses of action to address ongoing or emerging global challenges; and (iii) it advises interested Governments on the ways and means of translating policy frameworks developed in United Nations conferences and summits into programmes at the country level and, through technical assistance, helps build national capabilities.

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GLOSSARY OF ACRONYMS

AAU	Addis Ababa University
AAVP	African AIDS Vaccine Programme
ACHEST	African Centre for Global Health and Social Transformation
ACTs	Artemisinin-based Combination Therapies
AMC	Advance Market Commitment
AMR	Annual Ministerial Review
ASEAN	Association of Southeast Asian Nations
AusAID	Australian Agency for International Development
AUTM	Association of University Technology Managers
BD	Becton Dickinson and Company
BMZ	Federal Ministry for Economic Cooperation and Development of Germany
BPN	Civil Society Best Practices Network
BWIs	Bretton Woods Institutions
CBMH	Community-Based Management for Health
CCMs	Country Coordination Mechanisms
CHWs	Community Health Workers
CEB	United Nations Chief Executives Board
CHIPU	Complex Hospitalo Instituto Projecto Universitaire
CONGO	Conference of NGOs
CSDF	Civil Society Development Forum
CSDH	Commission on Social Determinants of Health
CT	CAT Scan
DAC	Development Assistance Committee
DACA	Drug Administration and Control Authority
DCF	Development Cooperation Forum
DDA	Doha Development Agenda
DDW	Diseases of the Developing World
DESA	Department of Economic and Social Affairs
DIPAP	Diabetes in Pregnancy Awareness and Prevention
DNDI	Drugs for neglected Diseases Initiative
DRC	Democractic Republic of Congo
DUs	Drug Users
ECOSOC	Economic and Social Council
ECV	Epidemic Control for Volunteers
EU	European Union
€	Euro
FBOs	Faith-Based Organizations
FDI	Foreign Direct Investment
FIND	Foundation for Innovative New Diagnostics
G 8	Group of Eight
G 20	Group of Twenty
GAWH	Global Alliance for Women's Health

GDF	Global Drug Facility
GDM	Gestational Diabetes Mellitus
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB and Malaria
GFMD	Global Forum on Migration and Development
GHWA	Global Health Workforce Alliance
GHP	Global Health Progress
GNI	Gross National Income
GNP	Gross National Product
GNP+	Global Network of People Living with HIV
GSPOA	WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property
HAPO	Hyperglycemia and Adverse Pregnancy Outcome study
H1N1	Influenza A virus
HDI	Health and Development Initiative
HIPC	Heavily Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IADGs	International Agreed development Goals
IAVI	International AIDS Vaccine Initiative
ICPD	International Conference on Population and Development
ICT	Information and Communications Technology
ICTSD	International Centre for trade and Sustainable Development
ICW	International Community of Women living with HIV
IDA	International Development Association
IFFIm	International Finance Facility for Immunization
IFIs	International Financial Institutions
IFPMA	International Federation of Pharmaceutical Manufacturers
IFRC	International Federation of Red Cross and Red Crescent Societies
IHP	International Health Partnership
ILEP	International Leprosy Relief Agencies
ILO	International Labour Organization
IMF	International Monetary Fund
IOM	International Organization for Migration
IP	Intellectual Property
IPPF	International Planned Parenthood Federation
IRENE	United Nations Informal Regional Network
IT	Information Technology
ITNs	Insecticide Treated Nets
IRS	Indoor Residual Spraying
ITU	International Telecommunication Union
KEMRI	Kenya Medical Research Institute
LEAP	Leishmaniasis in East Africa Platform
LDCs	Least Developed Countries
LICs	Low-Income Countries
MAHP	Microfinance and Health Protection Initiative

MDGs	Millennium Development Goals
MdM-F	Médecins du Monde-France
MDRI	Multilateral Debt Relief Initiative
MDT	Universal Multi Drug Treatment
MFIs	Microfinance Institutions
MHP	Migrant Health Program
MMV	Medicines for Malaria Venture
MoH	Ministries of Health
NICI	National Information and Communication Infrastructure initiative
NSs	National Societies
NVPs	National Voluntary Presentations
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NTDs	Neglected Tropical Diseases
NZAID	New Zealand Agency for International Development
OCCAM	Observatory for Cultural and Audiovisual Communication
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
OESC	Office for ECOSOC Support and Coordination
OHRLLS	Office of the High Representative for Least Developed Countries, Landlocked Developing Countries and Small Island Developing States
OSAA	Office of the Special Advisor on Africa
OSAGI	Office of the Special Advisor on Gender Issues
PDCI	Partnership for Disease Control Initiatives
PEPFAR	President's Emergency Plan for AIDS Relief
PNSR	National Program for Reproductive Health
PPPs	Public Private Partnerships
RAFT	Réseau en Afrique Francophone pour la Télémédecine
R&D	Research and Development
RBM	Roll Back Malaria partnership
RRT	Resource Requirements Tool
SANRU	Rural Health Programme
SARS	Severe Acute Respiratory Syndrome
SBA	Skilled Birth Attendants
SDRs	Special Drawing Rights
SET	Survey, Education and Treatment
SIDA	Swedish International Development Agency
SIDS	Small Island Developing States
SMEs	Small and Medium Enterprises
SRSS	Strengthening the Health System
STH	Soil-Transmitted Helminthiasis
SWAP	Sector-Wide Approaches
TB	Tuberculosis
TDR	Research and Training in Tropical Diseases
TICAD	Tokyo International Conference on African Development

UICC	International Union Against Cancer
UN	United Nations
UNCTAD	United Nations Conference on Trade and Development
UNDA	United Nations Development Agenda
UNDAF	United Nations Development Assistance Framework
UNDESA	United Nations Department of Social and Economic Affairs
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNIFEM	United Nations Development Fund for Women
UNESCWA	United Nations Economic and Social Commission for Western Asia
UNOP	United Nations Office for Partnerships
USAID	United States Agency for International Development
VL	Visceral Leishmaniasis
WB	World Bank
WDF	World Diabetes Foundation
WESP	World Economic Situation and Prospects
WESS	World Economic and Social Survey
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

PREFACE

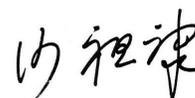
The 2009 High-level Segment of the Economic and Social Council (ECOSOC), held in Geneva from 6 to 9 July, focused on the theme of its third Annual Ministerial Review (AMR), "Implementing the internationally agreed goals and commitments in regard to global public health". The Council engaged all major stakeholders, including governments, intergovernmental organizations, civil society including NGOs, the private sector and global health public-private partnerships, giving needed impetus to worldwide efforts to achieve the Millennium Development Goals (MDGs) related to public health.

The Council focused on those areas where limited progress is impeding efforts to achieve the health-related MDGs, including health systems and women and girls' health, neglected tropical diseases and financing. The Council also addressed, in its thematic debate on "current global and national trends and their impact on social development, including public health", how the financial, food and energy crises as well as longer-term trends such as demographic changes, including migration, are impacting public health.

The deliberations and adoption of the Ministerial Declaration at the AMR helped to spur global momentum for cross-cutting action on public health at the country, regional and international levels. The Council stressed that health and poverty are inextricably linked and that achieving the health-related goals is central to sustainable development. In that context, Member States reaffirmed that good public health is better achieved through a combination of effective public-health and multisectoral policies that stress better nutrition, safe drinking water, hygiene, sanitation and sustainable urbanization, which all work in partnership to combat major risk factors. In addition, international cooperation and assistance – including through more predictable aid flows – should be better aligned with national development priorities and channeled to recipient countries in ways that strengthen their national health systems. The message is clear: development and public health must be pursued in an integrated way.

This book brings the deliberations of the Council to a broader audience by compiling the statements, issues papers and summaries of high-level roundtable dialogues of the ECOSOC session as well as the regional preparatory meetings of the AMR. It also presents highlights of the innovations featured at the Innovation Fair, the discussions at the NGO Forum, and Ministerial roundtable breakfasts.

As United Nations Secretary-General Ban Ki-moon stated at a special United Nations Forum on health in June 2009, "Health is the tie that binds all of the Millennium Development Goals together. If we fail to meet our targets on health, we will never be able to overcome poverty, illiteracy, achieve universal education and meet the other MDG challenges"¹. It is our responsibility to strengthen and scale up efforts to make the health goals a reality.



SHA ZUKANG
Under-Secretary-General for Economic and Social Affairs
United Nations

¹ See statement delivered by United Nations Secretary-General Ban Ki-moon on 15 June 2009, <http://www.un.org/apps/sg/sgstats.asp?nid=3918>

INTRODUCTION

Looking back at the Council's high level segment of 2009, I very much see it as the successful conclusion of a broad-based, six-month process.

Through thematic events at Headquarters and regional preparatory meetings held in Sri Lanka, China, Qatar, Jamaica and Ghana, each devoted to a theme particularly relevant for the region or sub-region, the Council was able to touch upon many dimensions of global public health and to put them at the centre of the development agenda.

The Ministerial Declaration adopted at the conclusion of the high-level segment promotes consensus on a broad range of issues that are of major concern to populations around the world, from widespread communicable and non-communicable diseases to neglected tropical diseases, and from health systems and services to universal access to reproductive health. In addition, the Declaration is a pragmatic document that promotes concrete measures to advance the realization of the global public health goals.

Opened by the Secretary-General and the President of the Swiss Confederation, the discussions involved high-level policy-makers and lead speakers, such as the Director-General of the World Health Organization and well-known advocates on global health issues. The Executive Heads of key international partnerships in health, including UNAIDS, UNITAID, the Global Fund, Roll-back Malaria and Stop TB Partnership, presented the lessons learned from these multi-stakeholder initiatives and their potential for further improvement.

A special event on Africa and the Least Developed Countries was organized for the first time during the high-level segment, drawing on the ability of the Economic and Social Council to connect substantive policy discussions to the broader development agenda, and to the needs of the developing world. Two thematic roundtables on "global social trends and their impact on public health" and on "aid effectiveness in the health sector" were also held, gathering a mix of policy makers at the national and international level including, for example, the Chair of the Development Assistance Committee of the OECD (OECD/DAC), as well as civil society representatives.

An Innovation Fair where over 30 entities from the United Nations system and the civil society at large showcased innovative projects, clustered around three topical sub-themes, namely Information and Communication Technology Tools for Health, Innovative Partnerships for Health and Access to Health for Vulnerable Populations, was also organized by the Department of Economic and Social Affairs during the high-level segment.

Thanks to this multi-stakeholder mobilization, this year's ECOSOC has set the stage for follow-up actions such as the development of action plans or multi-sectoral partnerships on health challenges.

The national voluntary presentations by seven countries (China, Bolivia, Jamaica, Japan, Mali, Sri Lanka and Sudan) during the high-level segment generated stimulating discussions both on successful policies that could be replicated and on ways to address continuing development challenges. They were a testimony to the unique platform the Council provides to engage the global community in support of national efforts to achieve the Millennium Development Goals.

4 Introduction

I wish to recognize with appreciation the crucial involvement of the United Nations system (UN Secretariat, specialized agencies, funds and programmes) in this process, and their active contribution to the high-level segment, including through the participation of high-level officials, the organization of Ministerial breakfast roundtables and of special events held in parallel to the official programme, and their support to the regional meetings as well as to the preparation of the National Voluntary Presentations.

The events just described provide for the structure of this publication which intends to give credit to the actors that have demonstrated great commitment to promote the global health agenda and to connect it to the broader United Nations development agenda. Given the wealth of expertise that it covers and the acute needs that are at stake for a majority of the world's population, it is our hope that this book will contribute to keep the momentum that the Council has strived to generate and will inspire further efforts in order to achieve the international health related objectives in the near future.



H.E. Ms. Sylvie Lucas
President of the Economic and Social Council
Permanent Representative of Luxembourg to the United Nations

Chapter 1

ACHIEVING GLOBAL PUBLIC HEALTH

Overview

The Economic and Social Council (ECOSOC) organized its third Annual Ministerial Review (AMR) on the theme “Implementing the internationally agreed goals and commitments in regard to global public health” during the high-level segment in 2009.

Efforts to improve global health outcomes were addressed in light of the current economic and financial crisis. A number of keynote/guest speakers drew attention to some of the most critical health issues of our time, namely the slow progress made in improving maternal health, and the importance of addressing non-communicable diseases, neglected tropical diseases and communicable diseases. Many speakers emphasized that women bear a disproportionately high disease burden. In this regard, it was proposed that policies need to reflect the social context of countries and societies. It was also noted that as social, political and economic factors are primary determinants of health, there is a need for coordination among different policy sectors. They were unanimous in primary health care and sound health systems in building the foundation for underlining the importance of healthy societies.

This chapter presents some of the challenges and actions considered at the AMR. The following is a synopsis of the contributions outlined in this chapter.

Mr. Ban Ki-Moon, Secretary-General of the United Nations, underlined that this year’s **Millennium Development Goals Report** delivers a message that the current economic environment makes achieving the goals even more strenuous. He stated that many determinants of health lie outside the health sector. Some factors include ethnicity, gender, and socioeconomic status. He emphasized his concern for maternal health noting that it is a barometer of the functioning of public health systems. In conclusion, he spoke of key policy messages, such as, the need for more multi-sectoral approaches, the need to achieve clean water and sanitation targets, and the need for a major shift towards women and girls, and the leadership role of governments in strengthening national health systems in partnership with community leaders, faith-based organizations and the private sector.

H.E. Ambassador Sylvie Lucas, Permanent Representative of Luxembourg to the United Nations and President of ECOSOC, stated that the theme of this year’s AMR is particularly vital in times of crises. She stressed key messages from various regional meetings, which included the following: (i) governments need to take the lead in developing effective health systems; (ii) more sustained investments are needed; (iii) the growing challenge of non-communicable diseases needs to be given precedence, and (iv) multilateral approaches and international cooperation have a high chance for success. Moreover, she emphasized that for many countries, improving health outcomes is linked to education, agriculture, finance, and foreign affairs. Although there has been progress in encouraging a “whole-of-government” approach, Ambassador Lucas stated that strong follow through and leadership are still needed.

Mr. Hans-Rudolf Merz, President of the Swiss Confederation, stated that, in the context of the current global crisis, the MDGs are essential in guiding efforts in the fight against poverty. He described how the current pandemic demonstrates that health is a fragile public good that must be protected. Mr. Merz acknowledged that, while recently, progress has been made in the field of global health, more can still be done. Of all the public health indicators, maternal health reveals the most evident inequalities between rich and poor. He stressed that both the United Nations and a multilateral response were needed to fight poverty. He emphasized that ECOSOC serves as a political forum for global dialogue on new trends in the areas of economic and social development, as well as functioning as the United Nations system's coordinator. Hence, he underscored the need to strengthen ECOSOC.

H.R.H. Princess Muna Al-Hussein underlined that progress in the area of public health had stalled, especially in respect of global maternal mortality. Her Royal Highness emphasized that health systems were weak because of poor planning, poorly coordinated aid and unbalanced investments in basic health infrastructure. She stated that health in rich and poor countries was threatened by three universal trends: population ageing, rapid unplanned urbanization and the globalization of unhealthy environments and behaviors. As a result, the conditions that cause most deaths and disability in developing countries are non-communicable diseases (NCDs). She stressed that the rise of these diseases in developing countries has exposed the burden of long-term care on health systems, and as such must be addressed both at the global and national levels, in order to put an end to poverty in 2015.

Mr. Urmas Paet, Minister of Foreign Affairs of Estonia, stressed that the economic recession has put health systems under a lot of pressure. His overall message was that insufficient international cooperation and the failure to see health as a contributor to economic growth are the two biggest challenges associated with the global health system. Mr. Paet's recommendations were: firstly, to promote international cooperation in coordinating the efforts of the United Nations, governments, NGOs and the business community, and to promote the building of public-private partnerships; secondly, he detailed how the efficiency of the existing health systems has to be improved; and thirdly, he stressed that the focus should be on research and innovation in the medical field and the development of new technologies.

Mr. Nicolas Schmit, Delegate Minister for Foreign Affairs and Immigration of Luxembourg focused on the importance of sustainable health systems. While recognizing the overall progress made towards achieving health-related goals, he referred to the lack of progress in reducing maternal and neonatal deaths. He underscored the need for collective effort between the governments and donor nations in achieving a sound health system. The governments' willingness to establish policies that address health issues and women's inclusion in decision making in areas that affect them was of paramount importance. In addition, he encouraged the donor countries to be generous in supporting health issues through funding, training of health workers and strengthening of existing systems so that the progress already made is not nullified.

Dr. Margaret Chan, WHO Director-General, pointed out that the crisis faced today was of a different nature. It revealed the fundamental flaws in the policies and systems

governing the nations and sectors. In addition, they showed the interconnectedness of the nations as the mismanagement of one sector in one nation affected grievously other sectors and nations that had not contributed to the problem. She highlighted the negative impact of the financial crisis, changing climate, industrialization and globalization on the health sector. She encouraged the maintenance of the current momentum for better health, with special attention on the MDGs. In closing, she reiterated the concerns of different nations to include a moral dimension to the international system and have policies that respond to the concerns and values of society.

Sir Michael Marmot, Chair of the Commission on Social Determinants of Health (CSDH), spoke on the topic of social determinants of health. He invoked the experience of two districts in Glasgow, Scotland, with a life expectancy difference of forty years, to emphasize that healthcare services alone are not the only cause of health disparity. He noted that social, political and economic factors are also primary determinants of health. Sir Marmot referred to the World Health Assembly's resolution calling on the World Health Organization to consider the social determinants of health. He also highlighted success in the area, in particular, the increased emphasis placed on social determinants of health by Spain and South America.

Ms. Cherie Blair of the Cherie Blair Foundation for Women focused on the subject of women and non-communicable diseases. Ms. Blair addressed the relationship between women's health and their capacity to play a full role in society. She invoked the inclusion of health in the preamble to the Universal Declaration of Human Rights in arguing that ill health and poor health care systems are a major barrier to the realization of women's potential. Where basic standards of healthcare are lacking, the main victims are girls and women. She argued that in societies where women are denied equal status, their health suffers. The mortality rates of mothers and new born children have remained constant and there has been little real action to combat and treat fistula. Ms. Blair identified that the major challenge for those involved in public health would be dealing with the increase in non-communicable disease related deaths in low and middle income countries. She reported that non-communicable diseases are the primary cause of death in every region except Africa and will be the cause of 75 per cent of deaths by 2020. Ms. Blair recommended increasing efforts to combat non-communicable diseases. In particular, she noted that non-communicable diseases pose a disproportionate risk to women. Ms. Blair concluded that two global challenges – the social and economic costs of non communicable disease and the wasting of women's potential should be tackled together.

Ms. Sara Omega Kidangasi, a fistula advocate from Kenya, spoke on the topic of maternal health and safe motherhood. Ms. Kidangasi described her own experience with obstetric fistula, the result of rape, which led to a life – threatening birth complication. Ms. Kidangasi outlined the context for assessing maternal health: a social-cultural context and the political and economic conditions. She argued that maternal health is not an issue of incurable disease but one of the value society places on women. The social context – beliefs, harmful traditional practices and gender discrimination - prevent women from making voluntary informed choices. Ms. Kidangasi argued that women must be able to make choices about pregnancy and that women's right to access life opportunities should be protected. Political and economic conditions such as poverty and civil war directly impact maternal health. Ms. Kidangasi noted that universal sexual and reproductive

healthcare requires increased funding, and concluded that the community has great influence if it can be involved in advocating safe motherhood.

Transcending Global Crises and to Achieve Development Goals¹

By H.E. Mr. Ban Ki-moon
Secretary-General
United Nations

We meet in difficult times. The crises of the past 12 months -- the energy crisis, the food crisis and the current economic crisis -- have caused widespread hardship and grief.

They have also shown how closely our fates are linked. The influenza pandemic is the latest reminder of our vulnerability and mutual interdependence.

The growing impacts of climate change are also a source of grave concern, and a threat to all the Millennium Development Goals. This is why we must Seal a Deal in Copenhagen in December.

Such challenges demand our full collaboration -- all nations working together for the benefit of all people. They demand a renewed multilateralism based on universal principles and buttressed by resources, political will and respect for internationally agreed commitments.

This year's Millennium Development Goals Report delivers a message that should not surprise us but which we must take to heart: the current economic environment makes achieving the goals even more difficult.

Higher food prices in 2008 have reversed the nearly two-decade trend in reducing hunger. Momentum to reduce overall poverty in the developing world is also slowing. Tens of millions of people have been pushed into joblessness and greater vulnerability. Some countries stand to miss their poverty reduction target.

The target for eliminating gender disparities in primary and secondary education by 2005 has already been missed.

If we are to achieve the sanitation target, 1.4 billion people must gain access to improved sanitation by 2015.

We have been moving too slowly to meet our goals. Yet the report also shows that when we have the right policies, backed by adequate funding and strong political commitment, actions can yield impressive results.

Fewer people today are dying of AIDS. Many countries are implementing proven strategies to combat malaria and measles, two major killers of children. We are edging closer to universal primary education. We are well on our way to meeting the safe drinking water target.

We can and must build on these foundations.

In Africa and across the developing world, we have abundant evidence that aid can help transform lives. But delays in delivering aid, combined with the financial crisis and climate change, are slowing progress.

This is why, when I meet with world leaders, I have repeatedly called for solidarity and special attention on the poor – those least responsible for the crisis, and those least able to bear its impact. I did so in April at the G20 London Summit. I will do so again at the G8 meeting two days from now.

The G8 and G20 have made specific commitments to increase financial and technical support to developing countries by 2010 to achieve the MDGs.

Those commitments include raising annual aid flows to Africa, yet aid remains at least \$20 billion below the Gleneagles targets.

I urge the G8 to set out, country by country, how donors will scale up aid to Africa over the next year.

The credibility of the international system depends on whether donors deliver.

The United Nations, for its part, will continue to do its utmost to speak up for those most in need. As the President of ECOSOC said earlier, we are establishing a Global Impact and Vulnerability Alert System to be able to better track the impact of the economic crisis on the poorest and most vulnerable populations

The film² you saw at the opening of this session provides a sense of how we are trying to meet the demand from global leaders for better, faster information. This is absolutely vital if we are to mount a meaningful response.

Later this month, we will brief your representatives in New York and seek your feedback on how the system can best serve decision-makers. I plan to formally launch the system in September at the General Assembly.

Let me now turn to global public health, the focus of this year's Annual Ministerial Review.

Health is the foundation for peace and prosperity. Investments in health are investments in society. They save lives and benefit economies through improved productivity. Prevention efforts can avoid huge future expense.

However, many of the determinants of health lie outside the health sector. Even in wealthy countries, factors such as ethnicity, gender, socioeconomic status and geographical area dictate life expectancy. Gaps of more than a decade exist between different groups.

The MDG Report and my report to ECOSOC give a snapshot of where we stand.

Children's health shows mixed results. Some countries in sub-Saharan Africa have achieved significant success with key child-survival interventions. These are expected to produce further declines in under-five mortality over the next few years.

But many countries, both in sub-Saharan Africa and South Asia, have made little or no progress at all.

I am especially concerned about maternal health. This is the goal where we have seen least progress.

One woman dies every minute in childbirth. Ninety-nine per cent of these deaths are in the developing world. This should be unacceptable to us all – and a rallying cry for action.

Maternal health care is a barometer of how well a health system functions. If women have access to hospitals, clinics or trained community health workers, they are less likely to die in childbirth. These same facilities in turn reduce the burden of illness and deaths from other causes.

The MDG Report also shows the benefits of investments in health.

For example, a new and promising phase in the fight against malaria has begun. Countries are increasingly adopting more effective strategies to combat the disease. Immense efforts have been made to accelerate delivery of insecticide-treated bed nets.

We are also seeing a decrease in the global incidence of tuberculosis. Unfortunately, progress is not keeping pace with population growth, so the absolute number of new infections is still rising.

The health of 2.5 billion people is also threatened by continued lack of access to safe forms of sanitation.

So, the results are mixed, at best. The challenges to reaching the health goals remain formidable.

We need more multi-sectoral approaches, with a greater focus on reducing poverty, increasing incomes and providing decent employment.

We need to achieve our targets on clean water and sanitation, and provide education and basic sanitary information to all.

We must promote greater health literacy and behavioral changes that will reduce non-communicable diseases and tobacco and alcohol abuse.

We need shifts in attitudes, especially towards women and girls. We must also empower women. The expansion of paid employment for women was slow even before the economic crisis. Opportunities remain scarce in many regions. Women need access to employment, education and nutrition, as well as health care services.

We must use new technologies and engage doctors and health practitioners.

We must increase official development assistance in public health, including for building basic infrastructure.

Often small investments – for example in the area of neglected tropical diseases – can yield significant results.

Finally, governments should take a strong lead in strengthening national health systems in partnership with community leaders, faith-based organizations, charitable foundations and the private sector.

These are some of the key policy messages that have emerged through the regional preparatory meetings and the philanthropy event in New York.

Let us take full opportunity of this forum to move towards the common goals we have set for ourselves.

Collective Action in Public Health: Finding Solutions through Global and Regional Cooperation³

By H.E. Ms. Sylvie Lucas
President of the Economic and Social Council
Permanent Representative of Luxembourg to the United Nations

Since the beginning of the year we have collectively worked to bring to the forefront the challenges faced by the world community in the area of development. With the grim predictions of “the worst depression since the 1930s”, we were all too aware of the fact that maintaining momentum towards our development priorities in times of crises was not going to be easy. This is particularly true for the Millennium Development Goals in the area of global public health. We have seen in the past that social sectors suffer the most during crises.

The theme of this year’s Annual Ministerial Review “Implementing the internationally agreed goals and commitments in regard to global public health” is therefore particularly opportune and timely. In times of crises, maintaining our pledges to health goals becomes increasingly difficult, especially in developing countries across the world. Worse, the poorest and the most vulnerable are hardest hit, as they are the least likely to seek health care with even less resources at hand.

To address these challenges and bring forward concrete ideas for action to this session, we have engaged in an intense and broad preparatory process covering major aspects of the health and development agenda.

Let me begin with the role of partnerships and innovative approaches. The influx of innovative resources and multiple stakeholders has opened the way to novel structures, networks, partnerships and alliances beyond traditional health and development models. A special event on “Philanthropy and the Global public health agenda” was held in February to shed light on the role of philanthropy in health. Its critical role in addressing the challenges of maternal health and reducing child mortality, neglected tropical diseases as well as finding innovative ways of financing health systems to reduce the global burden of such diseases were thoroughly discussed.

We also discussed the valuable yet often neglected role of traditional medicines in the global public health agenda in another special event earlier this year.

In preparation for the AMR, various regional ministerial meetings have furthermore been organized over the last months, bringing forward specific regional health concerns. The first regional meeting, held in Sri Lanka, focused on the theme “Financing strategies for healthcare”. A meeting held in China addressed ways to promote health literacy. The Government of Qatar hosted a meeting on “Addressing non-communicable diseases and injuries”. The Latin American and Caribbean Ministers meeting in Jamaica addressed the theme of HIV and Development, whereas the regional meeting for Africa, which was

held in Accra, focused on the topic of “e-Health - information and communication technology for health”.

While I would not like to preempt the presentations we will hear later this morning from the various regional meetings, allow me to point to some key messages, as I see them.

Firstly, governments need to take the lead in developing effective health systems. Their efforts must however be complimented by other stakeholders. Local communities, civil society organizations, philanthropists, the private sector, as well as international cooperation, in line with national systems and priorities, are all crucial factors for better, for more equitable health outcomes.

Secondly, more sustained investments are needed to support the health agenda. This includes fair systems of health financing, a well trained and adequately remunerated human workforce as well as a system of governance that ensures equity, participation and efficient use of resources.

Thirdly, the growing challenge of non-communicable diseases needs to be given high priority. NCDs and injuries cause 60% of the deaths globally. Cardiovascular diseases, diabetes, cancer and chronic respiratory diseases are shaving the health budgets not only in developed countries.

Fourthly, relatively modest investment in the fight against neglected tropical diseases (NTDs) would have an enormous effect and take a heavy burden of the shoulders of the most vulnerable, especially in developing countries.

Fifth, commitments made to combat the communicable diseases should be honored. While progress has been made in dealing with HIV, TB and malaria, there is a continued need for vigorous action. The synergies between AIDS response and strengthening of health and social systems should furthermore be maximized. We should more particularly aim at eliminating the mother-to-child transmission of HIV by the year 2015. 3

Sixth, the ICT resolution offers tremendous potential for significant health outcomes. If rooted in a comprehensive national development strategy and health program, e-health can prove a very cost-effective way of making health care accessible.

Finally, multilateral approaches and international cooperation have the greatest potential for success. This has again been made absolutely clear with the emerging of new and unforeseen health threats and epidemics, such as most recently the H1N1 flu. Viruses know no borders and neither should we in promoting the health agenda.

While these global and regional meetings organized in preparation of the Annual Ministerial Review have offered broader perspectives, the National Voluntary Presentations we will hear over the next two days, provide an opportunity to focus on national success stories or unique challenges that a country is facing in achieving the MDGs. I would like to thank Bolivia, China, the Dominican Republic, Jamaica, Japan, Mali, Sri Lanka and Sudan for having taken the initiative of sharing their experiences with us.

I would also like to thank the Secretary-General for his initiative in convening a “Global Health Forum on Advancing global health in the face of crisis”, earlier last month.

Real and measurable progress has been made in health outcomes, such as in the areas of HIV/AIDS, TB, and reduction in child deaths. Serious gaps remain however. Progress in maternal health is for instance negligible. This does also impinge on the health of the newborn child. Increased political will and commitment is therefore urgently required to eliminate the unacceptably high global rate of preventable maternal mortality and morbidity in order to ensure the full and effective implementation of our human rights obligations in this field.

The inter-linkages between health and other elements of the UN development agenda can also not be ignored. Good health will not be possible without clean water and sanitation. Climate change and environmental degradation are going to have negative impacts on our health goals if urgent action is not taken.

In order to truly address the challenges of health, we have to address the pervading inequities in health among and within countries. Most of the differences are attributable to the conditions in which people are born, grow, live, work, and age. Underlying problems of gender inequality are a crucial part of these inequities, reflected in the great differences in the health of women and girls who are often lagging behind men and boys. We must address the impact of the social determinants of health and establish effective social protection systems in order to ensure universal access to health care.

Managing the risks and rewards of health and development is increasingly a critical challenge facing all stakeholders. A unique opportunity exists to maximize multi-stakeholder participation in promoting collaborative action on the global health agenda through the Economic and Social Council.

Accomplishing the health goals remains a daunting task for many countries as improving health outcomes is linked not only to the provision of health services but also to the active involvement of decision makers in sectors like education, agriculture, finance and foreign affairs, to name just a few.

We have made some progress in promoting a “whole-of-government” approach. But, strong follow-through, firm resolve and leadership are needed to keep the momentum. It is time now to help foster our common development objectives. It is time now to make this session and this Council count.

Reaffirming the Development Commitment⁴

By H.E. Mr. Hans-Rudolf Merz
President
Swiss Confederation

It was here at the heart of Europe that the first pillars of the multilateral system were built. It was here in 1919 that the League of Nations, the precursor to the United Nations system, was born. Since then, Geneva has become a centre of global diplomacy, as well as a place where dialogue and mutual respect are cherished. In many respects, this ‘Spirit of Geneva’ also symbolizes Switzerland’s international commitment to these values. I hope that this spirit accompanies the work of ECOSOC and enables it to find responses to the challenges that the world must address.

At a time when the weakest feel the full force of the financial and economic crisis, thus rendering the task of fighting poverty even more arduous, it is necessary to reaffirm our commitment to development, based on respect for human rights. The Millennium Development Goals are at the heart of this commitment. In the context of the current global crisis, they must remain the compass by which we guide our efforts in the fight against poverty. The financial and economic crisis must not prevent us from pursuing the Millennium Development Goals.

The ECOSOC Annual Ministerial Review is an opportunity to assess the state of progress in achieving these goals. It is particularly timely that the topic of this year’s ministerial review is public health. The current pandemic demonstrates powerfully that health is a precious and fragile public good and that we must do all we can to protect it. It also shows us the need for effective and equitable public health systems, not just to assure the basic health of the whole population, but also to contribute to the security that is necessary for social and economic development.

While substantial progress has been made in the field of global health in recent decades, we must redouble our efforts to achieve the goals that we have set ourselves. Of all the indicators on public health, maternal health is the one that reveals the most striking inequalities between rich and poor: each year, half a million women die in developing countries due to complications in pregnancy or during birth. As the Secretary-General stated in his address to the last World Health Assembly, maternal health is a barometer of the functioning of public health systems. That is why Switzerland supports the concerted efforts of the WHO, UNICEF and UNFPA, which form the spearhead of the United Nations’ efforts to fight this scourge, responsible for the deaths of so many mothers and children every year.

In order to face these growing global challenges, we are in need of a universal organization such as the United Nations which can guide our efforts towards a freer, fairer and safer world. Daily reality shows that without a multilateral response, the fight against poverty and inequality will remain a lost cause.

Within the United Nations, the Economic and Social Council plays a leading role. ECOSOC is a political forum for global debate on new trends in the field of economic and social development. Furthermore, as the UN system's coordinator, ECOSOC has to assure the coherence and efficiency of United Nations operations. As we find ourselves confronted with financial, economic and food crises, both these roles are more important than ever. It is therefore in the interest of all to strengthen ECOSOC.

With that in mind, I sincerely hope that the Council's deliberations will help to overcome our common challenges. I therefore wish you the necessary success to fulfill this great responsibility.

Combating Non-communicable Diseases to reach Health Related Development Goals⁵

By H.R.H. Princess Muna Al-Hussein
Hashemite Kingdom of Jordan

For a number of years, I have been associated with the World Health Organization and its work in several areas, and have been privileged to serve as the WHO Patron of Nursing and Midwifery. In this capacity, I have been most impressed by the engagement of world political leaders in the implementation of the MDGs.

For the first time, childhood deaths have dropped below the 10 million mark. The proportion of children under five years of age suffering from malnutrition has declined from 27% in 1990 to 20% in 2005. Billion-dollar commitments of Official Development Assistance for health have more than doubled over the last few years. Health has never before enjoyed such attention.

But these commitments are not enough. Progress has stalled. It disheartens me to see that the global maternal mortality ratio of 400 maternal deaths per 100,000 live births has barely changed since 1990. As we have learned over the past years, powerful interventions and the money to purchase them will not buy better health outcomes in the absence of stronger health systems based on primary health care.

Weak health systems are the bottleneck that slows progress and blocks the delivery of effective interventions. Health systems are weak because of decades of poor planning, poorly coordinated aid and unbalanced investments in basic health infra-structures, services and health workforce. My heart goes out to all the people with infectious diseases and peri-natal conditions who are facing, on a daily basis, health systems which are unable to respond effectively and equitably to their needs. I am also deeply moved when I witness how health systems miss early detection of breast and cervical cancers, diabetes, hypertension and other risk factors.

And this brings me to my main point. We face problems beyond those targeted by MDGs.

Health in rich and poor countries alike is now threatened by three universal trends: population ageing, rapid unplanned urbanization, and the globalization of unhealthy environments and behaviors.

As a result, the conditions that cause the most death and disability in developing countries now include cardiovascular diseases, cancers, diabetes, chronic respiratory diseases and injuries. Globally, 80 per cent of deaths from these non-communicable diseases is now concentrated in developing countries. Almost 50 per cent of these deaths are premature. A similar shift has happened with deaths from road traffic accidents and other injuries: more than 90 per cent of the world's road deaths occur in developing countries, while these countries only have 48 per cent of the world's vehicles.

Together, non-communicable diseases and injuries are responsible for 70 per cent of all deaths around the world, affecting developing countries dis-proportionally. The situation will have dramatically worsened by the time we reach 2015- the milestone which we have set as an international community to have put an end to poverty. Death from non-communicable diseases is forecasted to increase globally by 17 per cent between 2005 and 2015, but the greatest increase, 27 per cent, will be witnessed in the African region, 25 per cent in the Middle Eastern region and 21 per cent in Asia and the Pacific.

The rise of non-communicable diseases and injuries in developing countries has uncovered further problems. It has revealed the burden of long-term care on health systems and budgets. It has shown that catastrophic costs drive households below the poverty line. And it has shown us the bitter irony of promoting health as a poverty-reduction strategy at a time when the costs of health care themselves can be a cause of poverty.

The current financial crisis and soaring food prices will force many more households to turn to less expensive foods, which are typically high in fat and sugar and low in essential nutrients. Tobacco and alcohol use further reduce precious family incomes.

Stalled progress during the past years towards the health-related MDGs has forced a hard look at the consequences of decades of failure to make balance investments in primary health care.

Non-communicable diseases and injuries must also be addressed if we want to put an end to poverty in 2015. Households could be lifted from extreme poverty and hunger by enacting tobacco control policies, encouraging healthy diets and physical activity, reducing the harmful effects of alcohol, and enforcing road safety legislation to make roads safe for pedestrians, cyclists and motorcyclists. Millions of lives could be saved by incorporating successful approaches for prevention and control of non-communicable diseases into primary health care, schools and workplaces.

Strong scientific evidence is available to support these approaches and international experience has taught us what works. Working in partnership and multi-sectoral action is key. Success depends on action from all sectors of government, including transport, trade, taxation, education, social planning and development, environment, agriculture, urban planning, mass media and private sector.

Despite the enormous magnitude of non-communicable diseases and injuries in developing countries and its devastating impact on socio-economic development, we note that development agencies are virtually absent in providing technical support to build national capacities in these areas. The greatest burden of preventable death and disability, in both rich and poor countries, is being caused by the very conditions that are receiving least Official Development Assistance.

Fortunately, the need to include non-communicable diseases and injuries in the development agenda is now increasingly recognized. Under this year's leadership by the Prime-Minister of Qatar, ECOSOC has given a high profile to the need to include non-communicable diseases and injuries into global discussions on development. A number of recommendations for your consideration were prepared during a Regional Ministerial Meeting recently held in Doha. We need to continue this momentum.

In May of 2008, I spoke at the World Health Assembly. I referred to the rapidly rising smoking rates and obesity and the decline in physical activity in low- and middle-income countries, resulting in high rates of hypertension, diabetes and other related health problems. At that time, I was pleased to see that the World Health Assembly had adopted the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases. Today, I call upon all of you to support this call from the world's Ministers of Health to raise the priority accorded to non-communicable diseases in development work at global and national levels. In this respect, I sincerely hope that the recommendations of the Doha Ministerial Meeting will be given your highest consideration.

The Global Health Standard: Viewing Health Systems as More than Care⁶

By H.E. Mr. Urmas Paet
Foreign Minister
Republic of Estonia

I would like to touch upon some very urgent and challenging questions regarding global public health focusing on the progress of achieving the health-related Millennium Development Goals (MDGs).

As declared in the WHO Constitution, adopted in 1948, “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” It is also stated that the “highest attainable standard of health is a fundamental right of every human being.” This universal right seems very straightforward and simple, but for millions of people, it is yet an unreachable privilege. As the Director General of WHO, Margaret Chan has rightfully stated: “people should not be denied access to life-saving interventions for unfair reasons, including an inability to pay”. One has to admit, that to ensure this right equally for everyone, a lot remains to be done.

Ensured access to the best attainable health care has to go hand in hand with the improvement of the global health standard as the situation in this field is far from satisfying. There are major and often growing health inequalities also within countries. I would like to thank the WHO and other parts of UN system for the enormous job they have done in promoting global health around the world.

There are some encouraging signs of progress made over the last years. Child mortality has been reduced, as well as under-nutrition. However, in several developing countries, particularly in Sub-Saharan Africa, the death of children under five still remains unacceptably high. The keys to reducing it are clearly social and need to be urgently addressed. Also the analyses affirm that the progress towards health-related goals continues to be slowest in countries with severe social problems: with high HIV prevalence or those affected by conflict.

Step forward has been made in relation to HIV/AIDS, tuberculosis and malaria. This testifies that our concerted efforts can lead to results. The progress needs to be sustained and carried further in current challenging environment.

The lagging progress in maternal and newborn health is still worrying, causing great suffering around the world. Each year some half a million young women die of complications during pregnancy or childbirth, 99 per cent of them in developing countries and most of them for preventable causes for which there is effective treatment.

Millions of young women on our planet unfortunately live in conditions with limited access to maternal or reproductive health services, which are essential for improving maternal health and reducing maternal mortality. Access to family planning, skilled attendance at birth and emergency obstetric care are critical for making progress towards

this goal. The persisting lag in this field calls for more increased political leadership as well as for more resources to protect both the health and the rights of women.

Dr. Brock Chisholm, the first WHO Director General proposed already in the 1950s that the medical education has to be based on all the needs of the human organism from the start of his or her existence, including a healthy mother who knows what she is doing. Undeniably, the whole society has a role to play in this regard as it is estimated that the economic crisis will increase the number of unemployed women by up to 22 million this year alone.

Coming to the current global challenge - the economic crisis - that affects all of us, it has to be stressed that for the developing countries the implications are particularly strong. Therefore we may now face an even more urgent challenge. Economic recession has put the entire social sphere, including health systems, under a lot of pressure. It has to be kept in mind that good health systems should not be a luxury, but a fundamental part of the social and physical infrastructure.

It is also essential to realize that the health systems are more than health care, but also include disease prevention, health promotion and efforts to influence other policies to address health concerns. Improved health contributes to social wellbeing through its impact on economic development, competitiveness and productivity. The high-performing health system is a key contributor to this process. Despite the recent vital health results, due to increased funding by foundations and global funds (For example Global Fund to Fight AIDS, Tuberculosis and Malaria), the large funding gap in global public health, especially in health care systems, remains.

Well-built health systems can provide the base for the dramatic scale-up of interventions that is needed to meet the health-related MDGs. In this regard, the experience from disease-specific programs can be a valuable contribution to our efforts in ensuring well-managed, adequately staffed and well equipped health systems. Many lessons can be learned from the work of global health initiatives. Our challenge is to scale up and strengthen services for health in a coherent manner beyond all initiatives. But the improved co-ordination is vital even more broadly as the economical crisis has made the need to provide better aid for health even more evident. Hereby it is important to focus on the interlinkages between health-related goals and the overall development agenda.

It has to be admitted that the economic recession might also have a serious impact on the effectiveness of the international co-operation, including health-related activities. As the history has taught us, the economic difficulties have a global tendency to bring about worrying signs of protectionism. Protectionism not only encourages the unhealthy trade measures, but is also a threat to the public health system. Moreover, it also hampers the international co-operation that is conclusive in struggle against pandemics and other diseases.

Secondly, at the times of economic downturn, the governments might be tempted to economize on the public health expenditures and this is the most alarming sign as it will affect the needs of the poorest and most vulnerable. It is an imperative to safeguard social spending in order to preserve the gains made in many social areas, including the achievement of MDGs.

However, the economical disadvantages bring about the creativity and new thinking. Our goal has to be set on turning the downturn into our advantage. At the WHO European ministerial meeting in Estonia a year ago, Tallinn charter was adopted by the health ministers of 53 countries. They commonly underlined the importance of making smart investments into the health system and called other sectors to make health enhancing investments. At the same time, the ministers took upon themselves the accountability for measuring the performance of health system. The above-mentioned is even more relevant today as the situation is more alarming than before the global economic crisis.

Thereby I would argue that both the insufficient international co-operation and failure to see health and health system as a contributor to economic growth are the two biggest threats on the global health system today. But how to tackle these challenges?

Firstly, we need to promote the international co-operation in coordinating the efforts of the United Nations, governments, NGOs and the business community, and to foster the building of public-private partnerships. The importance of the co-operation and commitment of all actors has become very obvious to me during my several visits to Afghanistan, including to the hospitals of the southern region. Estonian experience in coordinating the health care-related activities in Helmand province in Afghanistan is encouraging and shows that we can make a real difference, even though it might be very difficult under extreme circumstances. Among other things, assignments like distributing mosquito nets have been carried out, thereby saving hundreds of lives. It goes without saying that in order to ensure the efficiency of our actions; we have to co-ordinate our activities with other actors involved in the health sector.

Secondly, the efficiency of the existing health systems has to be improved and demonstrated. When health systems are run and financed more effectively, thousands of lives can be saved. Here it is also essential to build effective partnerships with other sectors to deliver more affordable health services. By combining smart investments and smart economizing, not only health sector, but also other spheres, for example technology and science will benefit as well.

Thirdly, our focus should be set on research and innovation in the medical field as well as on the development of new technologies. The accelerated technological innovation will multiply the potential to improve global health and helps to mediate the health literacy in more advanced and modern global society.

Hereby I am calling to support the ECOSOC' M-health initiative, aiming to develop health care knowledge and health information access through mobile phones. In Estonia electronic health initiatives have gained speed since 2002, including digital health records, electronic medical history and the health bank. By now we are seeing fantastic benefits from the use of innovative technologies and we strongly believe that ICT is essential in health care systems.

In conclusion, it has to be emphasized again that the global financial crisis may have a serious impact on the efforts to meet the health-related Millennium Development Goals. In an increasingly globalized world, our response must be effective, coordinated, flexible and global.

A Strong Political Leadership for a Sustainable Health System⁷

By H.E. Mr. Nicolas Schmit
Delegate Minister for Foreign Affairs and Immigration
Grand-Duchy of Luxembourg

I am particularly pleased to be speaking to you here today, for several reasons.

The first is that the theme of our Annual Ministerial Review is one that is close to my Government's heart.

The second is that the Economic and Social Council, as the Organization's central coordination and consultation mechanism for economic and social development, has an especially important part to play in ensuring that the global partnership for development is achieved.

The third is that a representative of my country is President of the Economic and Social Council this year.

The translation into action of internationally agreed health-related objectives and commitments – the theme of our upcoming discussions – and, particularly, of Goals 4, 5 and 6 of the Millennium Development Goals is crucial to achieving sustainable development. At the same time, it is obvious that the other Millennium Development Goals, particularly those addressing extreme poverty and hunger, malnutrition, education, gender equality and environmental sustainability, have a considerable impact on health. Any progress towards those goals will undoubtedly facilitate the implementation of the goals more directly associated with health.

I am proud to recall that Luxembourg, along with its European partners, was the author of the World Health Organization initiative to conduct an annual follow-up in the World Health Assembly of progress towards the health-related Millennium Development Goals. That exercise complements the routine review of the Goals conducted by the Economic and Social Council.

There has been progress concerning some of the health-related MDGs, which we welcome. According to the World Health Organization, child mortality rates have thus improved, with the rate for the under-fives having fallen by 27 per cent since 1990. We are also on our way to win the battle to stabilize, and even reduce, the spread of tuberculosis.

However, it is most worrisome that we have made little - indeed far too little - headway in reducing maternal mortality.

Every year, over 500,000 women die of complications during pregnancy and childbirth. Given this appalling situation, the recent involvement of the Human Rights Council in this vital matter is most welcome. Its resolution on maternal mortality, morbidity and human rights is significant in its recognition that such a high rate of maternal mortality

amounts to a violation of women's right to life, health, equal dignity and non-discrimination. Clearly, any progress we make will depend on our political will to attack the underlying causes of women's vulnerability and inequality. We firmly believe that we must look at all avenues to improve women's situation and protect their health. One prerequisite in that connection is to reaffirm our commitment to universal advocacy of sexual and reproductive health and associated rights. We will also need to find ways of making women equitably involved in deciding how society is to function, particularly in connection with fair access to health care.

Concerning the fight against HIV/AIDS, the situation remains despite some improvement worrying. In 2007, there were two million deaths from the pandemic, and 2.7 million new infections. However, thanks to considerable effort, approximately one third of those infected with the virus now have access to treatment. With a determined further effort, we may be able to come close to stabilization around 2015.

We now need to act worldwide to set up and consolidate efficient response structures. In our view, there will be three main challenges to address in the coming years:

1. Access to both prevention and treatment services on an equal and fair basis for men and women, sexual minorities, intravenous drug users, sex workers and prisoners;
2. The quality of services offered – integrated services that are not separate for HIV and the co-infections of tuberculosis, hepatitis C and hepatitis B; services that offer risk reduction for drug users and clear separation between public health measures and preventive measures.
3. Strong political leadership combined with cooperation at all levels with civil society, non-governmental organizations and, above all, those living with HIV/AIDS.

My country strongly believes that the United Nations have a leading role to play in coordinating, strengthening and overseeing the fight against HIV/AIDS. The main international partners of Luxembourg's cooperation programme in this field are WHO, UNAIDS, UNFPA, UNICEF and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

While the progression of the HIV/AIDS pandemic is a worldwide concern, it affects concretely, on a day-to-day basis, the fate of millions of people in each of the countries represented here.

Although Luxembourg has a low incidence of HIV, the annual rate of new infections has doubled since the 1990s. The virus is mostly sexually transmitted. Depending on the year, between 5 and 15 per cent of new infections are by intravenous drug use.

Luxembourg has put in place a harm-reduction programme using drug substitutes and needle and syringe exchange facilities. The programme also operates in prisons.

Screening is performed on a voluntary basis, and requires informed consent. It is confidential and includes support in the form of counselling. Testing cannot be required on recruitment or while on an employment contract. No HIV test is required in

connection with immigration formalities and there are no travel restrictions for those with the virus. Access to treatment is actively encouraged. It is not linked to citizenship and is fully covered by social security.

Any future progress towards achieving the health-related Millennium Development Goals will depend heavily on the establishment of sustainable health care systems. The aim should be to put in place primary health care, making sure that account is taken of social influences on health. We urgently need to develop a roadmap to enable us to work single-mindedly towards this goal.

How do we get there? First and foremost, our governments must have the necessary will to set up and find national and international funding for such a system. Donors should be attuned to this, and set aside more official development assistance for health.

Public policies aimed at providing full access to health care and suitable social protection should be reinforced. There is no alternative if we are to work towards greater social cohesion. International cooperation can help to propel the strengthening of national systems, particularly when it comes to training health care staff who often seeks better opportunities abroad. Although investment in health has increased substantially in recent years, the financial and economic crisis must not be allowed to reverse the gains made. Social spending, including on health, must be maintained.

The World Health Organization should support developing countries to enable them to train staff and restructure their existing systems to make them more efficient. A renewed effort should be made, in cooperation with entities such as the International Labour Organization, to ensure universal access to health care for all inhabitants of all countries.

As many parties are involved in the area of global public health within the United Nations, in the international arena and within civil society, there must be close cooperation between them. In line with the principles of the Paris Declaration, it is up to developing countries to take individual responsibility for establishing their development strategies, including in the area of health.

Luxembourg has focused its development cooperation policy squarely on poverty eradication, in particular in the least developed countries. Its efforts are consistent with the goal of sustainable development in its social, economic and environmental aspects, with men, women and children at its centre.

In 2008, Luxembourg devoted 0.95 per cent of its GNI to official development assistance, putting it second in the world. It allocates over 15 per cent of its bilateral aid to health, making that field its primary focus for development cooperation.

The priority areas in this regard are child mortality, maternal health and combating infectious diseases, and, in the longer term, strengthening health care systems and access to primary services and care, as recommended by the World Health Organization.

Accordingly, in Viet Nam, Luxembourg's development cooperation programme, together with the United Nations Population Fund (UNFPA), has been supporting the authorities' efforts to implement the national population and reproductive health strategy. In that connection, assistance has been provided for programmes to improve quality of life, particularly in neglected and marginalized communities, by stepping up access to

information and services in maternal and neonatal health, with particular attention being paid to gender equality and to preventing domestic violence. It is a long term effort which Luxembourg has been backing since 2001.

As the Secretary-General highlighted in his report, the economic and financial crisis risks to wipe out the gains of the last decade.

We are currently performing “stress tests” on our banks to make a better determination of threats to the stability of the financial system. Should we not also be performing “stress tests” concerning poverty and the enormous risks that it carries with it? Can we accept the risk that, according to recent World Bank forecasts, another 46 million people may shortly sink below the poverty threshold?

This is the international community's greatest challenge.

In keeping with the decisions of the G8 and G20, which should be implemented rapidly, there should be no let-up in international efforts. The countries left most vulnerable by the financial and economic crisis are the poorest of the developing countries. Millions of men, women and children risk falling victim to malnutrition, disease and lack of education. Malnutrition and inadequate nutrition are a direct threat to health, and therefore to development.

The 1966 International Covenant on Economic, Social and Cultural Rights recognizes, I quote, "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

Health, as a vital consideration in sustainable development, but also and above all as a human right, must be placed at the centre of our efforts.

By facing the major challenge of health in a brave, lucid and determined manner, we will be able not just to consolidate the gains of the last several decades, but also to make significant improvements in the years to come. The life and quality of life of millions all over the world depend on such a commitment of solidarity.

Multiple Crises: Overcoming Enormous Challenges in an Interconnected World⁸

By Ms. Margaret Chan
Director General
World Health Organization

We are meeting at a time when the world faces multiple crises on multiple fronts. In a sense, this is nothing new. Floods, droughts, famine, war, pestilence, plagues, and economic booms and busts are familiar companions in the up-and-down cycle of human history.

But today's crises are different. They have some unprecedented dimensions. They are revealing, in ominous ways, what it means to live in a closely interdependent and interconnected world.

They are revealing some fundamental flaws in the policies and systems that govern the way nations and their populations interact internationally. Greed seeded the financial crisis, which sprang out of control as corporate governance and risk management failed at every level of the system.

Climate change is the price we will now inevitably pay for short-sighted policies. Fuelling the world's economic growth took precedence over safeguarding the planet's ecological health.

Today, we make such mistakes at great peril.

The fates of all nations are bound together as never before. Mistakes made in one part of the world spread very quickly throughout the international system.

As the economists tell us, the financial crisis is unprecedented because it occurs at a time of radically increased interdependence among nations. The consequences have been highly contagious, moving quickly from one country to another, and from one sector of the economy to many others.

As we are seeing, the consequences of flawed policies are also profoundly unfair. Even countries that managed their economies well and did not take excessive risks are suffering from the economic downturn. Likewise, the countries that contributed least to greenhouse gas emissions will be the first and hardest hit by climate change.

The different sectors of government are also bound together as never before. Policy spheres are no longer distinct. A short-sighted policy in one sector can rapidly have adverse effects on many others, and most especially on health.

Global trends, such as the industrialization of food production and the globalization of its marketing and distribution, help feed the world. But these trends have also contributed to a public health crisis.

I am referring to the dramatic rise of diet-related chronic diseases, especially in the developing world. This trend has, in turn, been exacerbated by the financial crisis and the food crisis.

When money is tight, the first things that drop out of the diet are usually the healthy foods, like fruits, vegetables, and lean sources of protein, which are nearly always more expensive.

Processed foods, rich in fats and sugar and low in essential nutrients, become the cheapest way to fill a hungry stomach. This is the type of diet linked to the rise of chronic diseases.

As this century progresses, more and more crises are likely to be global in nature, with global causes, and with global consequences that are unfairly biased against countries and populations least able to cope.

Let me remind you of a bitter irony. All this is happening at a time when the international community is engaged in the most ambitious drive in history to reduce poverty and reduce the great gaps in health outcomes.

We are in a mess. The financial crisis hit the world like a sudden jolt, and it hit the world where it hurts the most: money.

This is not the kind of crisis, like an earthquake or a flood, where some fortunate, unaffected parts of the world can generously assist those who are suffering. All countries, rich and poor, north and south, are affected. But this is a crisis that will hurt the poor the hardest and the longest.

Because of the financial crisis, people in rich nations are losing their jobs, their homes, and their savings, and this is tragic. In developing countries, they will lose their lives.

Climate change is a gradual and now inevitable event, but the effects of more frequent and more extreme weather events will be abrupt and acutely felt. Again, the need for humanitarian assistance, for victims of floods, droughts, storms, and famine, will grow at a time when all countries are stressed, to one degree or another, by climate change.

Just a decade from now, crop yields in some parts of Africa are expected to drop by 50%. Among Africa's poor, 90% depend on agriculture for their livelihoods. There is no surplus. There is no coping capacity. There is no cushion to absorb the shocks.

Already, around 1 billion people are living on the margins of survival. It does not take much to push them over the brink.

And now we have another great global contagion to contend with. Last month, the World Health Organization announced the start of the 2009 influenza pandemic. A pandemic which currently shows moderate severity in affluent countries could have a devastating impact in the developing world.

The gaps and inequities that we are all trying so hard to address are likely to grow even greater.

Crises like the food crisis, the financial crisis, climate change, and pandemic influenza will deepen the misery and worsen the health of people and countries that already suffer the most.

Too many models for development assumed that living conditions and health status would somehow automatically improve when countries modernized, liberalized their trade, and experienced rapid economic growth.

But this did not happen. Instead, differences, within and between countries, in income levels, in opportunities, and in health status, are greater today than at any time in recent history.

Globalization has not turned out to be the rising tide that lifts all boats. Instead, wealth has been created and spread in waves that lift the bigger boats but swamp or sink many smaller ones.

This is the lesson that experts and analysts in sectors with far more clout than health now see, loud and clear, because of the financial crisis. We are now hearing calls, from multiple world leaders, for transformational changes in the policies that govern the way the world works.

The international systems need to be re-engineered to incorporate a moral dimension. They need to be transformed by policies that respond to the concerns and values of society.

Let me conclude by briefly mentioning what I believe are some of the greatest challenges facing health development today.

First, we must maintain the current momentum for better health. Special attention must be given to the Millennium Development Goals. We simply cannot afford to stumble, or slow down for a moment. These crises mean that the price of failure just keeps getting higher.

Second, the strengthening of health systems must stay at the top of the global health agenda. Weak health systems ultimately blunt the power of all our noble efforts and ambitious goals.

Third, we must make fairness, as articulated by the values, principles and approaches of primary health care, our overarching goal.

And finally, we must make the prevention and control of chronic non-communicable diseases and the improvement of maternal health top priorities on the development agenda.

Both are entirely doable undertakings. Both are part of the agenda for strengthening health systems and revitalizing primary health care. Both are fully ready and mature areas for efficient interventions with a huge return. Both are begging for more attention.

I have a final remark, and a question. In a sense, the Millennium Declaration and its Goals operate as a corrective strategy. They aim to give this lopsided world a greater degree of balance, in opportunities, in income levels, and in health.

They aim to compensate for international systems that create benefits, yet have no rules that guarantee the fair distribution of these benefits.

They give us our best chance ever to introduce greater fairness in this world. But the Millennium Development Goals do not address the root causes of these inequities. The root causes reside in flawed policies.

Here is my question: When will the world finally see what most of us in public health regard as self-evident?

It is this. A focus on health as a worthy pursuit for its own sake is the surest route to that moral dimension that is so sadly lacking in international systems of governance. It is the surest route to a value system that puts the welfare of humanity at its heart.

Addressing Inequalities and ‘Closing the Gap’ in Global Health⁹

By Sir Michael Marmot
Chair
Commission on Social Determinants of Health

I want to start by saying what we meant by health equity. There are dramatic inequities in life expectancies between countries. Some countries in sub-Saharan Africa can have life expectancy as low as 40 years – for women it may be even lower. Women in Japan have life expectancy of 86 years. We start from the proposition that there is no good biological reason why there should be as much as 50 years difference in life expectancy in the world today between countries. These differences arise because of our economic and social arrangements.

And when we look within one Scottish city, the city of Glasgow, we see a life expectancy gap of 28 years. Men in the poorest part of Glasgow, have life expectancy that is eight years shorter than the average in India. Men in the richest part of Glasgow have life expectancy of the same order as Japan. By global standards, even the poor of Glasgow are rich. When you turn on the tap in Glasgow, the water that comes out is safe to drink. In the United Kingdom, we have a universal health care system free at the point of use. It’s not lack of health care that is responsible for this 28-year difference; it’s the operation of the social determinants of health that crucially impact on the lives people are able to lead. The experience of Glasgow tells us that we should not be focusing only on the poorest of the poor, important as that is.

Further argument that we should not be focusing only on the poorest of the poor comes from the recognition that health follows the social gradient. In country after country, we find a graded relation between wealth, or education, and health. Analyses from Demographic and Health Survey data in India, for example, show that those in the second wealth quintile from the top have higher infant mortality rates than those at the top. Those in the third quintile have higher mortality than those in the second quintile. It’s a social gradient, and that means if you focus only on the poorest of the poor, you miss most of the problem. The poorest of the poor rightly claim our attention, but the social gradient in health tells us that this is a problem of the whole of society. We need societal action, not just a focus on the very bottom.

The reason that I’m so pleased personally to be addressing ECOSOC is that it suggests the recognition that inequities in health are not the same thing as inequities in health care. Inequities in health care are of vital importance, but the major determinants of the inequities in health are, as the Secretary-General said in his speech, in the conditions in which people are born, grow, live, work and age.

The Commission on Social Determinants of Health identified three areas for action. The first was the conditions of daily life: conditions in which people are born, grow, live, work and age; the second was the structural drivers of those conditions, at global,

national and local level; and the third was the importance of evidence, monitoring, training, research, and capacity development.

In Oslo recently, the Minister of Foreign Affairs said “I am a Health Minister”. He said every minister of government is a ‘Health Minister’, and I would say that every sector is a health sector. What happens across the whole of government impacts on health equity, so much so that it’s reasonable to argue that health equity is a measure of how well we are doing in other sectors?

Filling this out then, in the conditions of daily life, we talk about the importance of early child development and education, of healthy places, fair employment, of social protection, and of universal health care. Among the structural drivers, crucially, we emphasize, building on the Finnish initiative, health equity in all policies.

The question is: Is anybody listening? And the answer so far seems to be yes. People are listening.

In Britain, the Prime Minister announced that in the light of the Commission on the Social Determinants of Health, he was inviting me to conduct a review of what the commission’s findings meant for action to reduce health inequalities in the United Kingdom. Brazil conducted its own commission. I had the honor to present a copy of our report to the Indian Prime Minister and we’re hopeful that action will take place in India. The President of Sri Lanka indicated his enthusiasm for Sri Lanka being a country that will take this issue seriously.

At the World Health Assembly in May, there was a resolution based on the report of the commission that called on all member states, called on the multilateral international community and crucially called on the WHO to take action here.

Often I’m asked what is the role of the Ministry of Health? If you’re emphasizing what happens in the other social spheres is crucial to health, where does the Minister of Health fit in? And you could ask the same question where does WHO fit in, and my answer is three-fold.

Firstly, those of us in the health sector need to ‘put our own house in order’. We need to develop universal access; people should not be denied because of inability to pay. The health system should be more oriented to prevention than health promotion.

Secondly, the health sector should be the advocates across government; we care more about health than anyone else, but we know the action has to take place elsewhere, so we should be the advocates for working across government.

And thirdly, the importance of measurement and understanding the problem is likely to come from the health sector. What I think applies to Ministers of Health applies to the World Health Organization. We would like to see WHO take the lead in the international community.

There are encouraging regional activities. Spain has indicated that when they assume the Presidency of the European Union in January 2010, they will make social determinants of health and health equity a priority for their presidency. In South America, 12 countries have now formed their own commission on social determinants of health.

Our report which we entitled ‘Closing the Gap’ was based on the assumption that we have the knowledge that we need. We have the means in our hands to close the health gap in a generation. The question is what do we have in our hearts?

We said that closing the gap is a matter of social justice – we should do it because it is the right thing to do. It is an intensely moral issue. We put at the center of what we were trying to achieve empowerment, which we think of as material, psycho-social and political, having voice. In the spirit of social justice, we seek to help create the conditions for people to lead flourishing lives.

Women, Global Health, and the Increase in Non-Communicable Diseases¹⁰

By Ms. Cherie Blair
Founder
Cherie Blair Foundation for Women

My expertise is very much in law not in health. And nor am I a politician with the experience of meeting unlimited health needs with limited resources- although through Tony I have seen these pressures first hand. But what I do have is a passion, professionally and personally, for championing the issue of women's rights- and helping lift barriers through my Foundation for Women which prevent women playing their full role in our societies.

There is no doubt that ill health and poor health care systems are a major barrier to these goals- something explicitly recognized in a wide range of international conventions for over 60 years. The enjoyment of the highest attainable standard of health was specifically seen as a fundamental right when the World Health Organization was set up. Health was also rightly included in the pre-amble to the Universal Declaration of Human Rights.

Recognizing something as a fundamental right is, of course, a vital first step. It does not on its own, as we all know, ensure these rights are upheld and safeguarded. In many parts of the world, even basic standards of health care are lacking. And the main victims of this injustice are girls and women.

It should be no surprise sadly that the burden of ill-health and poor health provision falls disproportionately on women. As the WHO has noted: "health is linked to status in society. It benefits from equality and suffers from discrimination". And because women are still being denied equal status in many societies, their health suffers- and through them, the health of their families and communities. This discrimination starts right at the beginning of life.

I know I am not alone in questioning whether over half a million women every year would still die unnecessarily around childbirth if men, too, became pregnant.

Despite progress in meeting many Millennium Development Goals, the mortality rates for mothers and new born babies have remained largely unchanged. Nor have we seen concerted action to prevent and treat fistula- a humiliating condition from which two million women suffer globally.

It is clear, as these statistics underline, that improving maternal and child health and care must be an absolute priority. But we must also step up efforts to tackle the impact of non-communicable diseases on women.

There is a growing realization that NCDs are a silent epidemic threatening our hopes for improving global health. They are already the major killer in every region apart from

Africa. By 2020, even conservative estimates predict they will be the cause of three out of four deaths worldwide.

Increasingly we will see these deaths in low and middle-income countries, holding back our hopes of spreading prosperity. Yet, despite the efforts of many people here today, the threat that NCDs pose still does not get the attention, or the resources, needed.

Diabetes, for example, already kills as many people as HIV/AIDS each year. And while the rate of new HIV/AIDS infections is thankfully falling, the number of new cases of diabetes continues to rise sharply.

Indeed, NCDs are responsible for twice the number of deaths caused by infectious diseases, yet receive only a tiny fraction of national and development health funding.

No one, I should stress, is arguing for a reduction in efforts or funding to tackle infectious diseases which cause such suffering and damage.

What we must do, as I know you are pressing to happen, is at the same time increase our efforts to combat NCDs. This includes looking, in particular, at the serious impact of these diseases and conditions on women. There are a variety of reasons why women are at special risk from the remorseless rise in NCDs- reasons which again rest on their lack of status within their societies.

It is true, of course, that women live longer than men. But this largely genetic advantage does not mean, for many women, that these extra years are healthy. We know that women are far more likely than men to live in poverty which has a major impact on health. And societies in which priorities are set, and decisions take, largely by men are less likely to put an emphasis on the health needs of women.

Even if there were medical resources to detect early and treat medical conditions such as cervical and breast cancer, in many societies women still have to overcome a deep-seated traditional resistance to seeking treatment.

I have seen for myself for example in Pakistan how women feel embarrassed about monitoring their own bodies and how this prevents the vital early diagnosis and treatment for breast cancer.

The tragedy, of course, is that we know the major steps that need to be taken to reverse this tidal wave of non-communicable diseases. There is overwhelming evidence, for example, that action to cut tobacco use, improve diets and increase physical activity would have a powerful impact on big killers such as heart disease, type 2 diabetes and cancer.

The reverse is also true. If, for example, the rate of smoking in women in China was to be allowed to approach the level of men, it would have a devastating impact on the country's health and the cost of health care.

There is no single answer to this immense challenge.

We need, of course to continue increasing resources, national and international, for health care. We must improve health education for women, alerting them to the particular risks they face. We must make better use of female health professionals to extend care and

encourage women to seek treatment- and use non-professional but persuasive voices to champion the cause.

It is important, as well, that women are given a voice in setting health priorities and shaping policies to meet them. But we must also be honest.

These measures will only have their full effect if we continue working to ensure equality for women in every society. The world cannot afford the social and economic costs of non-communicable disease. But nor can it afford to continue to waste the potential of half its population.

These two battles must be fought and won together.

Overcoming Great Obstacles in Maternal Health¹¹

By Ms. Sarah Omega Kidangasi
Maternal Health Advocate
Kenya

I got involved with fistula activism after a successful repair surgery in May 2007, which ended my 12 years of suffering with the condition.

With special emphasis on maternal health, I stand in strong support of the theme, “Implementing the internationally agreed goals and commitments in regard to global public health”.

I have a conviction that the story of a woman is the story of the society. Her success is our success, and what affects her, affects all of humanity. The billion-dollar question is “How safe is motherhood?”

Records indicate a disgusting reality. A woman dies every minute from complications arising from pregnancy and childbirth. More than ½ a million die a year.

On average, in a year 15 million others suffer severe health problems, or are left with life threatening disabilities like fistula, which has a devastating mix of medical, social and psychological consequences.

It is disappointing to note that maternal health is the area of least progress, of all Millennium Development Goals. In the 21st century when the world has both skills and means to make motherhood safe, it is heartbreaking that a woman should die while she gives life. It is not an issue of incurable disease, but simply our indecision as a society to count the worth of a woman.

Since a vast majority of these hard realities happen in the developing countries, with sub-Saharan Africa, most affected, it is important to highlight the context. This will act as an eye opener at this conference, and a pointer to the right course of action in improvising maternal health.

Maternity is generally compromised in two basic settings namely, (i) the socio-cultural context, and (ii) the political and economic context.

In socio-cultural context, beliefs, values, harmful traditional practices, illiteracy and gender discrimination prevent women from making decisions about their own lives. Their only option in life is limited to childbearing irrespective of the risks involved. This must change, or we must force it to change. Women need the ability to have a wanted pregnancy and the ability to avoid a pregnancy that is not welcome. Our right to access health, nutrition, education and life opportunities should be promoted and protected.

Political and economic conditions such as poverty and civil war also have a direct impact on maternal health. Lack of basic resources, poor infrastructure, limited access to reproductive health care, insecurity and all related factors need our solidarity,

commitment and action to end. Access to universal sexual and reproductive health care calls for increased funding.

I speak with conviction, passion and emotion, on maternal health, because every woman has a right to live, laugh and live again. I personally grew up in abject poverty. Orphaned at the age of 11, I dropped out of school for lack of fees, and got pregnant at 19 through the beastly act of rape. From that dehumanizing encounter, I developed a life threatening birth complication- obstetric fistula. Night and day for 12 years up to May 2007 my life was continually put on the verge. With uncontrolled leaking of urine, foul smell, stigma, isolation, pain and rejection, it was like dying every day.

While still in the hospital after the repair surgery, is when I learned that I am just one among millions of women who die or suffer disabilities related to pregnancy and childbirth. This reality pushed me to action of not watching another woman die or suffer as I suffered.

I am thankful to UNFPA for their support and funding that has broadened my vision for safe motherhood to the global level. I have advocated for safe motherhood at the “Women Deliver Conference” in London, October 2007 and several events on Capitol Hill in 2008. With support from UNFPA I put emphasis on community outreach because the community has great influence if involved in advocating for safe motherhood.

My fulfillment in life is when I can contribute in giving a woman a life and a genuine smile. My call to the universe is to make maternal health a priority.

We should not allow another woman to suffer that. We need to move in with strong policies, advocacy, systems and funding. Let the woman live, laugh and live again.

Notes

- 1 From the 2009 ECOSOC high-level segment, 6 July 2009.
- 2 A film showcasing the United Nations Secretary-General’s initiative on “Global Impact and Vulnerability Alert System” to monitor the impact of crisis in real-time: http://webcast.un.org/ramgen/ondemand/conferences/ecosoc/2009/ecosoc_intro_vid_e090706.rm
- 3 From the 2009 ECOSOC high-level segment, 6 July 2009.
- 4 Ibid.
- 5 Ibid.
- 6 Ibid.
- 7 Ibid.
- 8 Ibid.
- 9 Ibid.
- 10 Ibid.
- 11 Ibid.

Chapter 2

HIGH-LEVEL POLICY DIALOGUE ON CURRENT DEVELOPMENTS IN THE WORLD ECONOMY AND INTERNATIONAL ECONOMIC COOPERATION IN THE CONTEXT OF ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS

Overview

How should the international community respond to the current global economic and financial crisis? How can the global economy be put back on track? What are the implications of the economic downturn for development and developing countries and the achievement of the Millennium Development Goals (MDGs) by the 2015 target date? To what extent could a successful conclusion of the Doha development round provide an urgently needed boost to the world economy? These were some of the questions discussed during the high-level policy dialogue among the representatives of the United Nations Department of Economic and Social Affairs (UNDESA), the World Trade Organization (WTO), the United Nations Conference on Trade and Development (UNCTAD), the International Monetary Fund (IMF) and the World Bank, which was held during the high-level segment of the Economic and Social Council (ECOSOC) on 6 July 2009, at the United Nations in Geneva.

Mr. Sha Zukang, Under-Secretary-General of UNDESA, emphasized that the crisis will continue to hit developing countries through several channels of transmission, from tighter conditions for international financing to higher costs of borrowing, a sharp fall in global trade, declining remittances and a possible fall in aid flows. Moreover, developing countries face a reduction in infrastructure investment, drop in social spending, increasing costs of achieving the MDGs and renewed external debt problems. Most of the heavily indebted poor countries (HIPC) and one-third of the countries in Sub-Saharan Africa are already at great risk of debt distress. Significant steps have been taken in response to the crisis, which include fixing the financial system, unprecedented fiscal stimulus packages, and massive availability of new international liquidity. There is now an agenda for reform of financial regulatory frameworks and of the international financial institutions. Yet, much more concerted international action will be needed to overcome the crisis and its most potentially devastating effects, especially on development and developing countries.

Mr. Pascal Lamy, Director-General of the World Trade Organization (WTO), pointed out that international trade, although one of the most regulated drivers of economic activity, has also been hit by the worst economic crisis in generations. The WTO predicts that trade volumes will fall by about 10 per cent in 2009 and that the poorest economies around the world will be those hardest hit. There are several reasons for the fall in trade volume. Firstly, protectionism is a real threat. While so far there is no evidence of high intensity protectionism, several trade restrictive measures have been taken by some

countries in the form of tariffs, new non-tariff measures, anti-dumping and countervailing actions that exceed the number of trade opening measures. Secondly, there was a sharp reduction in available trade finance. The G 20 has made a strong start in addressing this problem by pledging \$ 250 million to support trade finance through export credit agencies and multilateral development banks. But the contraction of trade credit is part of the broader liquidity crisis and developing countries in particular report ongoing difficulties in obtaining the bank credits they need to finance transactions. Furthermore, Mr. Lamy stressed that the most significant step, which the WTO could take to bolster the world economy, is to conclude the Doha development round. In conclusion, he emphasized that it is essential to envision an opportunity in this crisis as well, because it presents a unique opportunity to reform the trading system into a more equitable one, which is adapted to the commercial concerns of the 21st century.

Mr. Supachai Panitchpakdi, Secretary-General of the United Nations Conference on Trade and Development (UNCTAD), highlighted the multi-faceted consequences arising for developing countries from the current economic crisis, which are twofold. The decline in trade and related flows is accompanied by a decline in capital flows. He then went on to outline a potential exit strategy from the present economic situation. Firstly, there is a need for pragmatic and diverse policies to govern the respective role of the state and the market. Single policy prescriptions for all countries are inadequate and even dangerous. The so-called market efficiency cannot, on its own, correct the gross imbalances that precipitated the current crisis. In this regard, UNCTAD applauded the International Monetary Fund's (IMF) decision to relax ex-ante lending criteria and the G20's decision to make \$ 250 billion worth of Special Drawing Rights (SDRs) available through the Fund. This provision of liquidity will give developing countries access to cheaper credit and possibly assist them with the necessary countercyclical stimulus to their economies. Secondly, he stressed that a workable exit strategy requires not just a global response but also an inclusive approach, one that includes those who are suffering as a result of the crisis, but did not contribute to it. This requires a diversity of representation in the international economic governance structure. In this context, he welcomed the current efforts to reform international institutions like the IMF and World Bank and to create a more inclusive financial stability board to replace the Financial Stability Forum.

Mr. Maurilo Portugal, Deputy Managing Director of the International Monetary Fund (IMF) gave an overview over the global economic prospects and identified policy challenges, as well as exit strategies in regard to the global economic crisis. The IMF's updated projections for global growth for 2009-10 will reflect a modest improvement for 2010. This reflects improving prospects in emerging Asia, especially China and India, and the United States. However, global economic recovery will be fragile, with risks tilted to the downside. The main policy priority remains restoring the health of the financial sector. Macroeconomic policies also need to stay supportive, but start preparing the ground for an orderly unwinding of extraordinary levels of public intervention. At the same time, there has to be a rebalancing of global demand from key current account deficit to surplus countries. This will require coherent sequencing and clear communications by both fiscal and monetary authorities. Multilateral coordination is likely to be needed to mitigate cross-border distortions during exit. Both private and public savings will need to rise in the advanced economies for a sustained period to repair

damage to balance sheets. Economies reliant on export-led growth in recent years need to adjust their policies and become more supportive of domestic private demand. Greater exchange rate flexibility in some economies could also support the rebalancing of domestic and external sources of growth. Labour market reforms to enhance flexibility would help speed up the reduction in employment, while reforms in product and services markets to strengthen competition and productivity could help mitigate the effects of tighter investment financing. The IMF has also taken several steps in response to the economic crisis. It has substantially increased lending and reformed and increased the flexibility of the lending framework. The IMF has furthermore introduced a quick-disbursing facility without ex-post conditionality for strong performing countries that borrow in international capital markets. For low-income countries, concessional lending is being significantly increased, debt relief initiatives are being continued, and lending policies are being reformed to allow for more flexible, short-term, precautionary and emergency financial assistance. Programme design in IMF's financial assistance has also been adapted to the current global crisis circumstances. Recent programmes in crisis-affected countries provide for higher social spending, strengthening social safety nets, and better targeting of existing social protection systems. Finally, the IMF supports efforts to strengthen global governance of international financial institutions. These reforms include rebalancing of the IMF's quota shares to better reflect the relative positions of countries in the evolving world economy and to give greater weight to the more dynamic emerging market economies.

Ms. Joy Phumaphi, Vice President of the Human Development Network of the World Bank focused largely on the global credit crunch and its impact on demand, as well as the impact of the financial crisis on low-income countries. Firstly, the credit crunch in combination with uncertainty about future demand has delayed investment and severely reduced demand for durable goods. As a result, global trade and output had plummeted and world industrial production has fallen 15 per cent over the six months since the financial crisis intensified. While GDP growth in developing countries is expected to remain positive this year, the reality is that when China and India are omitted, GDP in the remaining developing countries is projected to fall 1.6 per cent. The slowdown in economic growth and much weaker capital flows have intensified financing pressures on many developing countries, with their overall financing gap viewed to range from \$ 350 to \$ 365 billion in 2009. Secondly, while initially cushioned from the direct impact of the financial crisis, low-income developing countries are now being affected as the crisis impacts have spread through other channels. World Bank projections indicate that net private capital flows will not be enough to meet the external financing needs of many low-income countries, while the prospects for large increases in other sources of financing are poor. For instance, the bulk of new commitments by international financial institutions (IFIs) will go to middle-income countries and remittance flows to low-income countries are projected to fall by 5 per cent in 2009. Therefore, without substantial increases in official finance, many low-income countries may be confronted with serious implications for their long-term development and poverty reduction. In charting the course ahead, policy makers must, therefore, consider three priorities, namely: (i) following up on the G20's promise to restore domestic lending and the international flow of capital; (ii) addressing the external financing needs of emerging market sovereign and corporate borrowers; and (iii) reaffirming pre-existing aid commitments and the MDGs.

For its part, the World Bank has stepped up its help to middle and low-income countries to help them navigate their way through the worst of the global crisis. It has committed US\$ 58.8 billion in fiscal year 2009 to help countries struggling amid the global economic crisis, a 54 per cent increase over the previous fiscal year and a record high for the global development institution.

The World Economic Situation and Prospects¹

By Mr. Sha Zukang
Under-Secretary-General for Economic and Social Affairs
United Nations

In the latest World Economic Situation and Prospects (WESP) report, the United Nations forecasts that the world economy will decline by 2.6 per cent this year. For the developing world as a whole, there will be zero per capita income growth. At least 60 developing countries will face reductions in average income, with people living in sub-Saharan Africa, Western Asia and Latin America suffering the sharpest declines.

Between 73 and 103 million more people are expected to remain poor or fall below the extreme poverty line of \$ 1.25 per day because of the global economic slowdown. Unemployment will rise significantly worldwide. All these developments will together generate significant setbacks in the efforts to reduce poverty and hunger.

The crisis will continue to hit developing countries through several channels of transmission, from tighter conditions for international financing to higher costs of borrowing, a sharp fall in global trade, declining remittances and a possible fall in aid flows. Developing countries face a reduction in infrastructure investment, drop in social spending, increasing costs of achieving the MDGs and renewed external debt problems. Most of the highly indebted poor countries (HIPC) countries and one-third of the countries in sub-Saharan Africa are already at great risk of debt distress.

Significant steps have been taken in response to the crisis. We have seen major public action to repair the financial system, unprecedented fiscal stimulus packages, and massive availability of new international liquidity. We have an agenda for reform of financial regulatory frameworks and of the international financial institutions. Yet, much more concerted international action will be needed to overcome the crisis and its potentially most devastating effects, especially on development and developing countries.

First, as analyzed in the WESP, more fiscal stimulus and closer international coordination of the stimulus packages are needed. This would help to reduce any leakage effects of fiscal spending measures and to enable a more comprehensive, long-term approach to economic policy making.

Second, the fiscal stimulus should work for all. Eighty per cent of the stimulus is concentrated in developed countries, while many developing countries lack the fiscal space to counteract the consequences of the crisis. More of the \$1.1 trillion in extra emergency financing should be made available to developing countries. Lending should be stepped up substantially; donors should accelerate the delivery on aid commitments; and temporary moratoriums should be placed on external debt obligations of those countries in severe financial distress.

Third, it will be critical to resist trade protectionism tendencies and intensify efforts to achieve a truly developmental outcome of the Doha Round of trade negotiations. To

further support a recovery of global trade, developing countries' access to trade financing must be restored and the promise of aid for trade fulfilled.

Fourth, enabling a continued flow of remittances will help economic recovery in many developing countries. For humanitarian reasons as well, we must strongly resist more limits on migration and discrimination against migrant workers.

Fifth, the world, and the developing countries, in particular, is facing multiple interconnected crises from the current economic and financial crisis to food insecurity, the persistence of widespread hunger and poverty, the increased frequency and intensity of natural disasters, and the imminent threat of potentially catastrophic climate change. We must use the opportunity of new, large-scale investments – including through stimulus packages – to set our economies and our planet on a more sustainable and equitable growth path.

I hope that this can be our shared view and that your deliberations will contribute to finding effective and concrete solutions that can lead us onto that path.

At this year's session, the Economic and Social Council will focus on the realization of the goals related to public health and the broad array of issues involved. While the financial and economic crisis poses many challenges, it should also be seen as an opportunity to reform health systems and to rethink the direction and nature of financing for health care. Hence, developing an agenda for health financing means not only more money for health but also more health for the money.

Even before the onset of the crisis, high reliance on out-of-pocket payments is estimated to have pushed more than 100 million people into poverty each year. The crisis threatens to reverse hard-won progress by developing countries toward the MDGs. Past crises show the imperative, in an economic downturn, of maintaining domestic support to the health sector. The international community must act to ensure the affordability, accessibility and the quality of health services to the poor and most vulnerable groups.

There is no one-size-fits-all policy on health care financing. Yet, countries' varied experiences do seem to suggest a general lesson: the importance of reducing reliance on out-of-pocket payments and moving toward pre-payment and pooling of funds, in order to avoid catastrophic health expenditure – and as steps toward achieving universal health coverage.

At a time when official development assistance (ODA) will become only more important for developing countries, donors need to uphold their commitments to the health sector. Where existing commitments are tied to decreasing gross national income (GNI), there may still be a drop in the value of aid. Donors need to ensure that this does not happen, especially in flows to the health sector.

It should be emphasized that without strong links to the process of poverty reduction, aid may not have positive impacts on the considerable health gaps that exist across and within countries.

ECOSOC should also give appropriate follow up to the decisions taken at the Doha Review Conference in December 2008 and at the United Nations Conference on the

World Financial and Economic Crisis and its Impact on Development, which took place in June 2009 in New York.

The outcome document, adopted on 26 June 2009, sets forth a number of specific proposals for tackling the crisis. The “way forward” section of the outcome document underscores the principle of inclusiveness in the global response to the crisis and collective understanding of its impacts. It calls for strengthening the capacity, effectiveness and efficiency of the United Nations, and enhancing the coherence and coordination of policies and actions between the United Nations, international financial institutions and relevant regional organizations. It requests ECOSOC, in particular, to pursue a range of related actions to follow up on the implementation of the outcome.

It is important to keep up the sense of urgency, for it is real. The opportunities presented by these multiple interconnected crises to put the world on a more sustainable and equitable growth path most not be lost.

Current Developments in the World Economy and International Trade²

By Mr. Pascal Lamy
Director-General
World Trade Organization (WTO)

Today the world is experiencing what is, by any measure, the worst economic crisis in generations and the first global crisis in the history of mankind. International trade, although one of the most regulated economic drivers, did not escape. WTO economists predict that trade volumes will fall by about 10 per cent in 2009. Other predictions go even beyond these figures.

Trade is one of the main drivers of economic activity. The multilateral trading system has always been an insurance policy and a stabilizing factor for traders around the globe, in particular, for many developing countries, who are actually feeling most of the heat now. The poor and weakest economies around the world - that have in no way precipitated this crisis - will be the hardest hit. Making things worse, prices are falling sharply for many of the commodities on which these countries depend for export earnings. The IMF warns that low-income countries could face a deterioration in the balance of payments of roughly \$ 165 billion.

Protectionism is a real threat. While the world has, so far, not seen high intensity protectionism a drip of measures taken by countries which can only make recovery more difficult; continuous slippage; trade restrictive measures in the form of increase in tariffs, new non-tariff measures, anti-dumping and countervailing actions exceed the number of trade opening measures. We are also seeing bail-out packages and other rescue measures being adopted to help specific industries. The rationale behind these measures is to favour domestic goods and service suppliers at the expense of imports. Many of these measures fall within WTO rules and, so far, they have not triggered a tit-for-tat chain retaliation. However, it is clear that these measures have a chilling effect on trade flows, in general. The ILO summit just two weeks ago reminded all of us of the need to resist protectionism.

For this reason, WTO Members have asked us to be vigilant and report on trade measures, which is what the WTO has done. Three reports have been put forward to WTO Members in which developments in the trading system since the crisis began are closely monitored. The last one was released as recently as last week.

The WTO secretariat was able to verify that in the past three months, despite further slippage towards trade restrictive measures, high intensity protectionism has been avoided. Although 83 of the 119 reported measures are restrictive, the WTO does not imply that these measures run contrary to WTO rules. Nor did it suggest that the 17 per cent surge in anti-dumping initiations in the last 6 months of 2008 are unwarranted. What can be said definitely though is that these measures restrict trade.

The sharp reduction in available trade finance is another factor that contributed to declining trade figures. In today's market, there is a lack of transparency and an abnormally high aversion to risk. The G20 made a strong start in addressing this problem by pledging \$ 250 million to support trade finance through export credit agencies and multilateral development banks. But the contraction of trade credit is part of the broader liquidity crisis and although some progress has been made in pushing this problem to the fore and addressing it, developing countries, in particular, report ongoing difficulties in obtaining the bank credits they need to finance transactions. Trade finance is the oil of global commerce. It is vital to monitor developments in this sector, using the network of banks, governments and international institutions. There is a need to act in concert to exit the crisis.

The results of the recent United Nations Conference contribute to this belief. Beyond the clear support from the full United Nations membership for the Doha Round and WTO's role and functions in fighting this crisis, the summit has injected further political leadership on how we should deal with this crisis. The international community has a collective responsibility to ensure that this momentum continues. It is also certain that the full potential of institutions, such as the Economic and Social Council, need to be put to use to ensure global coherence and coordination of our respective actions.

There should be no doubt that the most significant thing the WTO can do to bolster the global economy is to conclude the Doha round. Monitoring protectionist slippages and ensuring that finance is oiling trade properly are important functions, but the Doha Development Agenda (DDA) remains the stimulus package that many WTO Members need now. It does not require trillions of dollars but rather, renewed political attention and energy.

In pledging to roll back barriers to trade in goods, services and agriculture, governments will have to send a powerful signal that they are ready to work together to build on, and improve, the open, rules-based trading system, which has delivered prosperity and stability for six decades.

Keeping trade open is an essential ingredient to help exit the crisis. But for many developing countries this will not be enough. The crisis is starting to have an impact on the social fabrics. It is affecting workers who are losing their jobs; immigrants who can no longer send remittances back home; and youngsters who are having enormous difficulties entering the job market. In the current circumstances, it is essential, that countries develop social safety nets, which will help to stabilize societies and prevent social unrest.

In order to fully reap the benefits of an open trading system, poorer countries need an accompanying aid for trade package to address their supply-side constraints and boost competitiveness. Just this morning the second global review of aid for trade was launched, which will evaluate progress made, to date, and ensure that we will keep the momentum, now that we are in the midst of the biggest global economic crisis ever. A significant leap forward has been made since the launch of the initiative in 2005. There has been a 10 per cent annual increase in funds committed, funding pledges today standing at more than \$ 25 billion annually; non-concessional loans add an additional \$ 27 billion. Developing countries have also mainstreamed trade into their development

strategies. The Enhanced Integrated Framework for Least Developed Countries will be up and running and the first two projects in Sierra Leone and Yemen launched.

As the crisis bites all countries and, in particular, the poorest, the momentum needs to be maintained. It must be ensured that aid pledges are kept and that promises are met, so that the weakest countries have the means to weather the storm. Failure to provide this critical support would deepen the impact of the crisis and could unravel their recent efforts to grow and to foster development. This is the message that the WTO will be delivering at the Group of Eight (G8).

There are busy months ahead. Clearly, the difficult economic times mean that our jobs will not be any easier. But, in every crisis, there is always opportunity. And the world has before it now an opportunity to act and to reform a trading system, which must be made more equitable and relevant to the commercial concerns of the 21st century. It also has an opportunity to provide a stimulus to trade, at a time when the world sorely needs it.

Global Growth Performance and its Challenges³

By Mr. Supachai Panitchpakdi

Secretary-General

United Nations Conference on Trade and Development (UNCTAD)

In just 18 months, the world economy has undergone a sea change. A year-and-a-half ago, the situation was one of sustained economic growth across countries, even in low-income economies like the least developed countries (LDCs), where growth patterns have been erratic for nearly two decades. It was a time of rising prices and reasonable expectations of achieving most, if not all, of the MDGs.

Today, however, what optimism there once was about achieving these goals has all but evaporated, leaving many poorer countries struggling to contain a burgeoning social crisis. Global economic health has taken a pounding. In the transition economies, for example - one of the most extreme cases - GDP growth has plummeted from more than plus 5 per cent to a projected minus 5 per cent this year. Such swings are neither sustainable nor acceptable for governments, business or the public, who are simultaneously savers, investors, consumers and wage earners.

In reviewing these and other current developments in the world economy, this presentation intends to focus on the dangers arising for developing countries from the current crisis and then look ahead to a potential exit strategy.

First and foremost - by this time, there is probably widespread agreement on this - in order to better serve the long-term needs of countries and their populations, global economic activities need to be better managed and monitored. Indeed, if anything, the current financial and economic crisis has clearly exposed the limitations of certain mainstream economic views, especially the "one-size-fits-all" approach to national and international economic policymaking. It has also reinforced the need for pragmatic and diverse policies to govern the respective roles of the state and the market, the balance between regulation and deregulation, the mix between fiscal and monetary policies, and so on. Such policies are crucial in tackling economic interactions in this increasingly interdependent world and its fast-changing national, regional and international economic systems. And, as the world grapples for solutions to the crisis, adequate attention must be paid to the importance of policy diversity - which has somewhat disparagingly been called "heterodoxy".

It is now widely acknowledged that the increasing openness of the international economic system has not only facilitated economic growth across countries and regions but has also been the channel for the transmission of falling demand - the main second-round effect of the crisis affecting developing countries. As a result of ensuing recession, UNCTAD predicts that global trade will fall by at least 6 to 8 per cent this year. That is, unfortunately, a conservative estimate; the final figure is likely to be somewhat higher. For developing economies, as a whole, this spells potential disaster, as exports represent more than 50 per cent of GDP. In central Africa, however, this proportion exceeds 130

per cent - as opposed to just 10 per cent in the United States. The outlook - especially for the small and low-income developing countries, where a high percentage of GDP is derived from export earnings - thus, appears dismal. Only some of the larger emerging economies like China and India will be in a position to insulate themselves from the fall in trade, thanks to the size of their internal markets and their unilateral policies on capital accounts and banking regulation, which have, so far, kept GDP relatively buoyant.

Other trade-related flows have also dwindled as a result of the crisis. Credit-for-trade transactions, for example, has contracted, although the \$ 250 billion made available for trade financing by the G20 may ease some of the immediate constraints. There has been a steady decline in freight and shipping: port traffic is down by 15 to 25 per cent in the world's largest container ports, and container carrying capacity is being withdrawn. On the positive side, a slight improvement in airfreight volume was reported this month, and the Baltic Dry Index - a benchmark for maritime freight costs - has recently risen. A word of caution is in order, however: These encouraging signs in maritime transport, along with modest increases in stock markets, stronger account positions for some banks, and a slowdown in the decline of property prices in some developed economies, have led to pronouncements of "green shoots". The implication is that global economic recovery is within sight.

UNCTAD believes that such pronouncements are premature, at best, and alarming, at worst, since they neither reflect the global picture nor mirror reality in the "real economy". Before searching for "green shoots", therefore, it might be better to take a step back and survey the "garden", as a whole. For example: global unemployment will rise by an estimated 50 million this year. In the United States, half a million people lost their jobs in the month of June alone. If that rate continues, the country's unemployment will rise to a level not seen in recent history. The situation is much worse in developing countries, where the capacity for social safety net measures is limited and more than 4 million people are falling into hunger each week. Normally, most of these countries would supplement their narrow domestic resource base with funds obtained from external sources, including development aid, concessional loans, foreign direct investment (FDI) flows, remittances, and export revenue. Unfortunately, however, the global recession has cut back on all of these sources of capital flows.

Recent data compiled by UNCTAD reveals that FDI inflows plunged by 54 per cent in the first quarter of 2009, compared to the same period last year, and much more of this year's decline is attributed to developing countries than was the case last year. This will damage countries' ability to upgrade their technological and productive capacities and generate employment. Among the looming global concerns and risks that may affect the investment plans of transnational corporations is a possible rise in protectionism by home-country governments. UNCTAD, which has a long history of reviewing international investment flows on an annual basis, has been asked, along with the WTO and the OECD, to monitor changes in investment policies and their impact on investment flows. Fortunately, to date, many of the investment measures taken by home and host countries in response to the crisis appear to have been mostly non-discriminatory in nature - unlike the rising protectionist trends affecting trade relations. This could, however, change.

In addition to private capital flows, such as FDI and migrant remittances, ODA remains one of the most important sources of income and investment for many developing countries. In fact, for most low-income countries, foreign aid provides the main, and in some cases the only, source of the financing needed to support public-sector programmes, develop infrastructure, build productive capacity and prevent a slide into deep recession and the loss of hard-earned exporting capacities. Hence, UNCTAD's deep concern about the impact of the crisis on aid flows. UNCTAD's analysis of previous banking crises suggests that aid budgets can fall by 30 per cent in the five years following a crisis; other studies put the figure at between 10 per cent and 60 per cent. Support for development programmes in national aid budgets has already been diminished by the economic downturn through backsliding growth rates (against which countries sometimes set the level of their development assistance) and the depreciation of donor currencies.

Without sufficient aid, countries suffering from the multiple crises of high food prices, high energy prices, and economic turmoil may now find it difficult to maintain the level of their imports and meet their debt service obligations. The debt burden for many countries already stands at over 40 per cent of GDP, and for more than half the LDCs, it is 100 to 150 per cent of GDP. In recent months, UNCTAD has repeatedly called for a debt moratorium for poorer countries similar to the one introduced after the Asian tsunami and Hurricane Mitch. A moratorium would potentially benefit all countries, as scarce foreign exchange earnings could be used to finance badly needed imports instead of servicing debt.

As referred at the outset "policy diversity" or a heterodox approach - the deliberately pragmatic use of diverse policy tools and strategies, in order to address specific problems - is gaining acceptance. Policymakers, academics, the media and the public increasingly recognize that single policy prescriptions for all countries are inadequate, even dangerous, and that so-called market efficiency cannot, on its own, correct the gross imbalances that precipitated the current crisis.

In this regard, UNCTAD applauds the IMF's decision to relax ex-ante lending criteria and the G20's decision to make \$ 250 billion worth of SDRs available through the Fund. This provision of liquidity will give developing countries access to cheaper credit and possibly assist them with the necessary countercyclical stimulus to their economies and with social protection. The \$ 250 billion earmarked by the G20 for trade finance is also welcome, along with the \$ 50 billion in aid. We must, however, insist on the urgency of delivering these funds and ensuring that developing countries have access to a significant proportion of them. The social and, indeed, humanitarian needs in poor developing countries are much greater and more acute than in the developed world and they require an accelerated response. This is even more crucial in light of recent figures forecasting poverty to affect another 53 million people this year worldwide. Rising poverty would have a severe impact on nutrition, education and health, and a possible feedback effect on employment and prospects for future poverty reduction.

Finding solutions to the current crisis - a workable exit strategy - requires not just a global response but also an inclusive approach, one that includes those who are suffering as a result of the crisis but did not necessarily contribute to it. For many years, UNCTAD has called for diversity of representation in the international economic governance

structure. Such diversity is imperative not only for enhancing the system's legitimacy but also for offering the range of views and positions that need to be considered in monitoring and regulating the system. In this context, current efforts to reform international institutions like the IMF and World Bank and to create a more inclusive financial stability board to replace its previous incarnation, the Financial Stability Forum, are highly commendable.

The economic boom-and-bust cycle has become all too familiar, with regular financial crises occurring at least every decade since the early 1970s. Granted, there were some specific elements to each crisis, and the proximate causes - most recently, defaults on subprime mortgages - were unique, although not unforeseen. Each time, however, there is a familiar pattern; the mechanism that leads to the crisis is always the same. A positive shock generates a wave of optimism, which feeds into lower risk aversion, greater leverage and higher asset prices, which, in turn, feed back into even more optimism, leverage and higher asset prices. At first, sceptical observers claim that asset prices cannot continue to grow forever at such a high rate. Enthusiasts answer that this time it is different. If the boom lasts long enough, some of the sceptics end up believing that this time is indeed different, and those who still remain sceptical are marginalized and ridiculed. But, of course, things never are different. At some point, the asset bubble bursts and the deleveraging process and economic crisis begin. Some of the excesses that led to today's crisis could nonetheless have been prevented - for example, by a regulatory framework based on a clear understanding of the underlying mechanism.

In short, the financial system - including exchange rates, the reserve currency, and monitoring and regulation - desperately needs more and better management, in order to avoid these cycles of boom and bust. UNCTAD has consistently advocated a multilateral approach to the management of the international financial system. The principle that cross-border trade transactions should be governed by multilateral rules and regulations overseen by WTO is now widely accepted and considered the norm. Exchange rate volatility and misalignment can have a far more distorting effect than tariffs. Beggar-they-neighbour policies compounded by currency devaluation could also incite a cycle of retaliation, through competitive devaluation or other protective measures.

Regulation in one area - trade - is rendered ineffective if another interconnected system - finance - is left unregulated. It is generally accepted that trade rules are necessary to make relations between trading partners fair. They also encourage stability through predictability and are non-discriminatory and transparent. If there is a belief in a fair world, then we have to acknowledge that similar principles as those governing international trade should be applied to finance - for example, with regard to the management of exchange rates and destabilizing short-term financial flows.

The question is: Have we learnt enough from past mistakes to ensure that we do not repeat them, or at least minimize their impact? If the answer is yes, then I strongly believe that before the current crisis is behind us, we have to think hard about an exit strategy. Because I have one overriding concern, and that is that this crisis could spin off into other crises - another debt crisis, for example; an intensified energy or food crisis; or an economic crisis of another sort. Indeed, some evidence suggests that some new crises are already on the horizon. What we most need, then, is a sound exit strategy - one that

looks to the past to learn from mistakes, looks to the present to determine our priorities, and looks ahead to consider every possible scenario.

Otherwise: Will we experience another financial crisis in 10 years' time? Will small and vulnerable economies, and especially the LDCs, be suddenly affected by growing debt burdens or dramatic reversals in growth rates? Will we still be applauding rocketing asset prices and yet anticipating collapse? The current economic situation creates both the need and the opportunity for a change in direction. The present relaxation of attitudes towards pragmatic policy design, including a greater role for the state in providing stability, stimulus and the socialization of risk, is the result of an emergency. But, we need to look beyond the emergency. We need to consider the post-crisis environment and the normalization of so-called heterodox thinking in policymaking for the safety of our financial system and also for stable and equitable economic development. Now is our chance, if we have the courage to take it.

The World Economy: Situation and Challenges⁴

By Mr. Murilo Portugal
Deputy Managing Director
International Monetary Fund

A. Overview of global economic prospects

Following a steep decline in global output in the last quarter of last year and the first quarter of this year, signs are emerging that the rate of decline in global activity is moderating, but the timing and pace of a durable recovery remain still uncertain. Progress in returning the financial sector to health will be key.

The updated Fund's projections for global growth for 2009-10 that will be released in the coming days will reflect a modest improvement for 2010, after the projected contraction of 1.4 per cent in 2009, we are envisaging an expansion of 2.5 per cent of the global in 2010, which is somewhat better than our April projection of a 1.9 per cent growth for the world economy. This reflects improving prospects in emerging Asia, specially China and India, and the United States. However, the global recovery will be fragile, with risks tilted to the downside.

Inflation will likely remain contained and upward pressures are not on the horizon, as output gaps continue to widen.

High-frequency data point to a return to modest growth at the global level. However, the recession is not over and the recovery is likely to be sluggish. The advanced economies, as a group, are still projected not to show a sustained pickup in activity until the second half of 2010.

Growth in emerging and developing countries will vary across countries and regions, with those more dependent on external bank-related capital flows being the most affected. Against a backdrop of weak external demand and tight external financing conditions, the projected modest growth recovery will be led by countries where domestic demand has the greater momentum, including from policy stimulus.

Policy interventions have helped conditions to improve financial markets but the situation remains far from normal. In advanced economies, public intervention has helped reduce fears of systemic events and equity markets have recovered some losses. However, impaired assets are still on bank balance sheets and the adequacy of bank capital remains a concern. External financing constraints on emerging economies appear to have eased but conditions remain fragile.

Overall, there remain serious risks: financial strains could be protracted, particularly if efforts to deal with problem assets and to boost capital are not followed through forcefully and loan performance continues to deteriorate. A loss in confidence in public finances over the medium term in countries that expanded debt and deficit substantially due to the crisis could lead to higher borrowing costs for both sovereigns and private sector, constraining growth. Trade and financial protectionism continues to be a concern.

B. Policy challenges and exit strategies

The main policy priority remains restoring financial sector health. Macroeconomic policies need also to stay supportive, but start preparing the ground for an orderly unwinding of extraordinary levels of public intervention. At the same time, policies in systemic countries need to facilitate a rebalancing of global demand from key current account deficit to surplus countries.

Credible exit strategies will be needed to unwind substantial public interventions in an orderly fashion, when market conditions permit and the recovery becomes firmly established. This will require coherent sequencing and clear communications by both fiscal and monetary authorities. Multilateral coordination is likely to be needed to mitigate cross-border distortions during exit.

The medium-term path for the global economy is likely to involve a rebalancing of the sources of demand and policy frameworks of systemic countries should facilitate this shift to sustain strong global growth. Both private and public savings will need to rise in the advanced economies for a sustained period to repair damage to balance sheets. In major economies reliant on export-led growth in recent years, policy frameworks should adjust to become more supportive of domestic private demand. Greater exchange rate flexibility in some economies could also support the rebalancing, of domestic and external sources of growth. Labour market reforms to enhance flexibility and mobility would help speed the reduction in unemployment; while reforms in product and services markets to strengthen competition and productivity could help mitigate the effects of tighter investment financing.

C. The IMF's response to crisis

The IMF has taken many steps to help member countries deal with the effects of the crisis in our lending, surveillance and policy advice functions.

Lending Function

The IMF has substantially raised lending; reformed and increased the flexibility of lending framework; and undertaken a major advocacy effort to expand its financial resources, so as to enable us to respond to the strong increase in the demand for lending:

- Lending commitments are now more than 11 times bigger than in the pre-crisis period, standing at a record level of close to \$160 billion, which compares with \$14 billion at end-2007 and \$ 86.2 billion committed in 1998 in the wake of the crisis in Asia.
- In parallel, it has undertaken a major overhaul of our lending framework: we introduced a quick-disbursing facility without ex-post conditionality for strong-performing countries that borrow international capital markets: it broadened the availability of high-access precautionary credit, and discontinued structural performance criteria for all IMF loans. For low-income countries, it is significantly increasing concessional lending, continuing debt relief initiatives, and working to reform our lending policies to allow for more flexible, short-term, precautionary, and emergency financial assistance to these countries.

- Programme design in its financial assistance has also been adapted to the current global crisis circumstances: recent programmes in crisis-affected countries provide for higher social spending, strengthening social safety nets, and better targeting of existing social protection systems. Wherever possible, the IMF has relaxed fiscal policy in low-income countries during this recession; fiscal targets were loosened in close to 80 per cent (18 out of 23) of African countries with an active IMF programme, and about a third of programmes in LICs include floors on social or other priority spending. Also, inflation objectives were substantially relaxed during 2008, as world food and fuel prices rose.
- Shareholders have agreed to a tripling of the resources available to the IMF to \$750 billion and a doubling of the IMF's concessional lending capacity.
- IMF membership is considering to inject \$ 250 billion into the world economy to increase global liquidity and international reserves through a new general allocation of "special drawing rights" (SDRs). The Executive Board of the IMF discussed this topic in June 2009, and supported a prompt allocation as a collaborative response to the crisis, meeting the long-term need for supplementary reserve assets. This will increase the reserves of low-income countries by \$ 19 billion, acting as a low-cost buffer for these countries and allowing some scope for sustainable countercyclical policies. The Board expected that the allocation would become effective by end of August.

Policy advice

In addition to its lending functions, the IMF has provided policy advice to its members both advanced and developing countries on how to best cope with the crisis.

The IMF's policy advice for dealing with this crisis focuses on two main areas: financial sector policies to stabilize the financial sector and reestablish the flow of credit in the economy; and a relaxation of monetary and fiscal policies – where possible – to help sustain aggregate demand.

Support for financial sector restructuring was, and remains, the top priority that the IMF has advocated consisting of three types of measures. (1) provision of adequate liquidity to financial institutions – and central banks have been very successful in this task; (2) action to cleanse banks' balance sheets, by removing or isolating toxic assets; and (3) recapitalization of viable banks and resolution of non-viable institutions, on both of which fronts more still needs to be done.

The IMF has also advised expansionary monetary and fiscal policies to support aggregate demand for countries that have low and sustainable debt positions and access to financing to do so. It has stressed that policies in these areas should be closely coordinated internationally to maximize their impact and reduce spillover losses. At the same time, as countries adopt short-term fiscal stimulus, the IMF also advocated countries should announce now measures to deal with long-term fiscal problems, such as those related to aging populations, pensions, increasing health costs. Such policies would not have any negative effect on current aggregate demand, as they are usually phased in gradually and would help to anchor expectations regarding long-term fiscal sustainability.

It is important to note that the IMF has recommended that all countries in a position to do so should engage to the extent possible in counter-cyclical measures. Naturally, the advanced and larger emerging markets maybe better placed to pursue stimulus packages, given their greater access to finance, but several developing countries have also been able to use their available fiscal space to take important measures to support demand. However, many others will need scaled-up concessional assistance to ensure that their higher deficits do not lead to a worsening of their debt situations.

D. Lessons for the future of the international financial system

In addition to lending and policy advice, the IMF, together with other international organizations, engaged in a careful analysis work of the causes of the present crisis. It identified critical areas for reform of the international financial architecture. These issues have been discussed in many different fora, including at the G20 Summits in Washington and London.

Regarding reforms of the system of financial regulation and supervision in advanced countries, the priority is to ensure that regulation and supervision cover not only risks posed to an individual financial institution existence, but also all potential sources of systemic risk arising from institutions, markets and products that are systemic. The IMF has started to work with the BIS and the FSB to define guidelines to help to identify systemic institutions and to identify tools to deal with them in an internationally consistent way. It is also important to effectively oversee cross-border transactions, with careful international coordination of national regulation, oversight, and resolution frameworks. During this exercise to strengthen surveillance, it is important that the trends towards both globalization and innovation are preserved, since these trends have been the major sources of dynamism in the global economy over the last decades.

With respect to improving the international financial architecture, a second area of concern, is to improve and make more effective the international surveillance of countries' economic and financial policies and of the global economy. Surveillance must identify better the sources of systemic risk, assess macro-financial linkages and spillover effects across countries. The Fund is trying to strengthen its surveillance framework. It is developing an early warning exercise to apply to systemically important countries to deal with tail risks to the global economy and plan to present such proposal in October during the Annual Meeting in Istanbul. It is also reviewing the Financial Sector Assessment Programme, including the improvement of surveillance over regulatory frameworks.

E. Governance reforms

The crisis has also prompted several pleas towards reform of international economic governance, including governance of international financial institutions. The IMF supports efforts to strengthen global governance and think that they should be based on three important principles: pragmatism, specialization and division of labour, and effective institutional cooperation among international organizations.

- Pragmatism seems to suggest that it might be more doable to reform and enhance existing institutions rather than create new ones. This is important not only because it is very difficult to mobilize consensus to create new organizations but also to avoid wasteful duplication.

- Specialization and division of labour among international organizations are also important to increase efficiency. Reform efforts should take into account the relative expertise and experience in specific areas and comparative advantages of each international organization, in order to generate greater overall efficiency.
- It is also essential to have effective institutional cooperation among international organizations because problems are multifaceted and interlinked and cooperation should be based on each institution's mandate and governance structure.

F. Reforming the governance of the IMF

The IMF had started to worry about improving its governance structure even before the crisis had started and have made some progress in this area since 2006. It will be accelerating the implementation of a package of reforms adopted in April 2008. These reforms include rebalancing the IMF's quota shares to reflect better the relative positions of countries in the evolving world economy, and to give greater weight to the more dynamic emerging market economies. The IMF has modernized its quota formula, trebled the number of basic votes, and approved *ad hoc* quota increases for the most dynamic emerging market economies. These reforms imply a shift of 2.5 percentage points of voting power in favour of developing countries. IMF members have agreed to bring forward a further review of quotas by January 2011.

Ideas are also being considered for achieving a more interactive and effective participation of ministers and governors in providing strategic direction on key issues. With increased globalization of trade and finance, there will be an increasing number of problems that would not have an optimal solution at the national level. Solving such problems may require greater international collective action and closer coordination of macroeconomic policy across countries than before. The IMF is a global inclusive international organization, comprising of 185 member countries. Its Articles of Agreement envisage that it should be a major forum for international cooperation among countries in monetary and financial issues. It may work as a facilitator of such international collective action and several ideas have been discussed for a reinvigorated IMF that could play that role.

Global Economic Outlook and Implications for Developing Countries⁵

By Mr. Joy Phumaphi
Vice-President, Human Development Network
World Bank

The United Nations Economic and Social Council (ECOSOC) meets for its annual session at a time of deep global economic recession and financial-market fragility. The world faces a contraction in GDP of 2.9 per cent this year, unemployment is soaring in the high-income countries and private capital flows are shrinking at a rate never seen before. While the World Bank projects a modest recovery next year, the world confronts many risks and must hope that a rebound in domestic demand in developing countries helps pull the world out of the doldrums.

The intervention focuses on two main points. First, the global credit crunch, in combination with uncertainty about future demand, has delayed investment and severely reduced demand for durable goods. As a result, global trade and output has plummeted, and the world industrial production has fallen 15 per cent over the six months since the financial crisis intensified with the failure of the Lehman Brothers investment bank. While GDP growth in developing countries is expected to remain positive this year, the reality is that, when China and India are omitted, GDP in the remaining developing countries is projected to fall 1.6 per cent. The slowdown in economic growth and much weaker capital flows had intensified financing pressures on many developing countries, with their overall financing gap viewed to range from \$ 350 to \$ 635 billion in 2009.

Second, while initially cushioned from the direct impact of the financial crisis, low-income developing countries are now being affected as the crisis impacts have spread through other channels. The World Bank's projections suggest that net private capital flows will not be enough to meet the external financing needs of many of low-income countries, while the prospects for large increases in other sources of financing are poor. For example, the bulk of new commitments by international financial institutions will go to middle-income countries, and remittance flows to low-income countries are projected to fall by 5 per cent in 2009. Without substantial increases in official finance, many low-income countries may be confronted with serious implications for their long-term development and poverty reduction.

While preliminary data from the OECD DAC suggests total official development assistance from DAC members rose to a record of \$ 120 billion in 2008, much more is needed during this period of global downturn to support growth and protect the poor and vulnerable.

On top of the crisis, the deadline for the Millennium Development Goals is six short years away from 2015. Strong economic growth in developing countries in the past decade had put the MDG for poverty reduction (halving the proportion of extreme poor in the population between 1990 and 2015) within reach at the global level. But projected

economic growth in developing countries is now, on average, only about a third of that forecast before the onset of the financial crisis. Past trends show that a decline in the average GDP growth rate in developing countries by one percentage point can trap as many as 20 million more people in extreme poverty.

Experience from the East Asia crisis and others has shown that failure to protect existing infrastructure during economic downturns can be very costly, resulting in substantially higher capital spending in the longer term. Moreover, with many low-income countries already off track on most of the human development MDGs, the global crisis threatens further setbacks. While progress towards the MDGs will likely resume when growth recovers, achievement of the goals will be further delayed. The long-run implications of the crisis for human development outcomes may be more severe than those observed in the short run.

When poor households withdraw their children from school, there is a significant risk that they will not return once the crisis is over, or that they will not be able to recover the learning gaps resulting from lack of attendance. The decline in nutritional and health status among children who suffer from reduced (or lower-quality) food consumption can be irreversible, retarding their growth and cognitive and learning abilities.

According to a recent Bank study “Averting a Human Crisis During the Global Downturn: Policy Options from the World Bank’s Human Development Network” 23 countries depend on foreign aid for more than 30 per cent of their total health spending and that maintaining donor aid flows during a crisis is urgent in order to safeguard health services. In Rwanda and Ethiopia, foreign aid donors subsidize more than 50 per cent of total government budgeted health spending. Governments have used this aid to expand their health services but they are highly dependent on uninterrupted aid flows to keep health services available to people, especially the poorest and most vulnerable groups.

The ability therefore of the development community to recognize and respond to the needs and interests of poor countries is essential to prevent the unraveling of their hard-won development gains of previous decades; and also to help as many countries as possible achieve the transformational promise of their MDGs.

Donors, including multilateral donors, have to demonstrate that they too are accountable for the substantial pledges of new aid made during recent G-8 summits. They also need to champion our side of the development bargain by embracing greater policy coherence and coordination, better alignment and harmonization in order to equip countries to strategically manage resources, especially during these troubling times in the global economy.

There is a growing risk of increased fragmentation and compartmentalization within countries and among external partners, making it vital to ensure that new initiatives are coherent with the agreed country and results-based approach to development assistance and with the Paris Declaration and the Accra Agenda for Action, reinforcing rather than undermining domestic processes and systems.

Looking ahead to the rest of 2009, developing countries will most likely face a dismal financing climate. In 97 of 108 developing countries for which data is available, the total financing needs in 2009 are estimated to be \$ 1.1 trillion, \$ 700billion higher than in 2003

(in constant 2009 prices). The ratio of financing needs to GDP for 97 countries is estimated at 7.8 per cent, up from 6.2 per cent in 2006.

Although extraordinary policy responses by governments have helped save the global financial system from collapse, they have not, thus far, closed the negative feedback loop between financial instability and economic recession. Fragile consumer confidence and a much diminished appetite for risk among investors have all contributed to a plunge in global aggregate demand. Simultaneously, the deepening economic recession has caused major global banks to scale back domestic and international lending, thereby making the credit crunch worse.

In charting the course ahead, policy makers in developed and developing countries should consider three priorities, namely: (i) following up on the G-20's promise to restore domestic lending and the international flow of capital; (ii) addressing the external financing needs of emerging market sovereign and corporate borrowers; (iii) and reaffirming preexisting aid commitments and the Millennium Development Goals (MDGs).

For its part, the World Bank Group has stepped up its help to middle and low-income countries to help them navigate their way through the worst of global crisis. It has committed \$58.8 billion in fiscal year 2009 to help countries struggling amid the global economic crisis, a 54 per cent increase over the previous fiscal year and a record high for the global development institution.

Commitments from the International Development Association (IDA), which provides interest-free loans and grants to the world's 79 poorest countries, totaled a record \$ 14 billion in the 2009 fiscal year, up 25 per cent from the 2008 fiscal year. To rapidly support countries affected by the crisis, \$ 990 million of this lending was provided under an IDA Fast-Track facility.

Three years ago, the developing world was experiencing its most rapid economic growth in four decades. Now it is struggling to contain a global financial crisis for which it bears no responsibility. Consequently, it will be very important for this week to send a message of hope from the Economic and Social Council here in Geneva to low-income countries that we will honor our aid pledges and where possible, step up to do more; that we will embrace our commitments to better alignment and coordination under the banner of aid effectiveness; and that despite the crisis, we will re-dedicate ourselves to achieving the 2015 MDGs.

Notes

- 1 From the High-level Policy Dialogue on current developments in the world economy and international economic cooperation which took place during the 2009 ECOSOC high-level segment, 6 July 2009.
- 2 Ibid.
- 3 Ibid.

4 *Ibid.*

5 *Ibid.*

Chapter 3

THE ANNUAL MINISTERIAL REVIEW: “IMPLEMENTING THE INTERNATIOALLY AGREED GOALS AND COMMITEMENTS IN REGARD TO GLOBAL PUBLIC HEALTH

PART A: ANNUAL MINISTERIAL REVIEW PREPARATORY MEETINGS

Overview

At the Special Event on “Philanthropy and the global public health agenda”, held in New York on 23 February 2009, more than 500 representatives from the private sector, philanthropic institutions, NGOs and academia participated in discussions with Member States and experts from the United Nations system on how to improve health outcomes for women and girls and how to raise awareness of the opportunities to prevent and treat neglected tropical diseases. Key steps to be taken described during the event included the following:

1. Recommendations for maternal and girls’ health;
 - Building basic health infrastructure (operation of health facilities/construction of dispensaries and local health posts – with a view to achieving universal access to services, focusing on rural areas);
 - Scaling up of community and mid-level health workers, while addressing the need for more highly trained and specialized staff (partially achievable through the development of corporate volunteer programmes);
 - Building a global partnership or Business Coalition for Maternal and Child/Girls’ Health, specifically dedicated to advocating for women and girls. This network of private sector companies, philanthropic institutions and international organizations could be formed to make specific contributions to existing partnerships programmes. It could be tasked with, *inter alia*, the development of an advocacy strategy targeting an increase in the involvement in the health of women and girls, the identification of partners’ contributions to specific programmes and the development of a global strategy/action plan for private sector and philanthropic involvement in women and girls’ health. Partners could include:
 - Pharmaceutical and health industries: develop new medicines and improve access to them and create innovating financing mechanisms (both micro-level and macro-level finance);
 - ICT companies: provide e-Care solutions, particularly for women and health care workers;

- Manufacturing companies: prevent child labour, child abuse, and educating women on their sexual and reproductive rights;
 - Food and beverage companies: set up business alliances at the national and regional levels to promote food fortification, school feeding programmes, and water sanitation/distribution schemes
 - Tourism companies: advocate and take measures directed to prevent sexual exploitation and sex trafficking;
 - Finance companies: support for microfinance schemes devoted to maternal and girls' health; and
 - Philanthropic institutions: provide donations and expertise on a wide range of issues affecting women and girls' health;
2. Recommendations for neglected tropical diseases:
- Investing in sustainable funding;
 - Allowing rapid approval and delivery;
 - Devising new intellectual property management policies to encourage needs-driven research and development;
 - Improving drug distribution and procurement;
 - Transferring relevant technology and strengthening research capacities in developing countries;
 - Creation of a network of partnerships on NTDs: All stakeholders involved in addressing various aspects of NTDs from research, advocacy, delivery of medicines, etc., could be brought together in the context of reporting to the Economic and Social Council on how they are contributing to the implementation of the health-related Millennium Development Goals (MDGs).

The South Asia Regional Meeting on “Financing strategies for health care” held in Colombo, Sri Lanka, on 16-18 March 2009, explored the key challenges which countries are facing in the area of both domestic and external financing of health systems. It also looked at health financing in post-conflict situations. The discussion took place against the backdrop of a worsening international economic and financial crisis. H.E. Mr. Sarath Amunugama, Minister of Public Administration and Internal Affairs and Deputy Minister of Finance and Planning of Sri Lanka, presented the following key messages to the Council at its 2009 Substantive Session:

- Ensure that the solutions to challenges in the health sector are geared towards the special needs and circumstances of countries;
- While civil society and the private sector can play an important role, the public sector has to take the lead role to deliver effective and equitable health services;
- Find ways to increase domestic funding and enhance efficiency in the use of resources to achieve universal coverage;

- Move away from reliance on out-of-pocket payments towards a system of prepayment and pooling to ensure equitable access to health care;
- Work towards increased and more predictable external funding, which is better aligned with countries' national priorities and channeled to recipient countries in ways that strengthen national financing systems;
- Ensure that innovative sources of health financing are additional and not a substitute for external ODA funding and address the problem of “donor darlings” and “donor orphans”; and
- Provide sufficient funding for health care in post-conflict or post-disaster situations, which is on par with funding on other areas in the recovery and rehabilitation phases.

The Asia and Pacific Regional Meeting Promoting Health Literacy, held in Beijing, China, on 29-30 April 2009 examined the issue of health literacy – the ability to gain access to, understand and use health information for promoting and maintaining good health – and its central role in improving achieving the health-related MDGs. H.E. Mr. Chen Zhu, Minister of Health of China, conveyed the following recommendations to the Council:

- Promote health literacy as a fundamental cost-effective strategy to prevent diseases, improve primary health care and promote of social development;
- Establish multistakeholder partnerships among governments, NGOs, private sector, enterprises, media and civil groups to promote health literacy;
- Base measures to promote health literacy on the social and cultural background of countries, based on a “people first” principle;
- Put particular emphasis on the promotion and enhancement of women's health literacy;
- Promote new initiatives, including the need to formulate global, regional and national action plans at the earliest possible time and define the connotation, measurement methods and indicators of health literacy; and
- Scale up evidence-based approach to planning and implementing projects and activities to promote health literacy.

The Western Asia Regional Meeting on “Addressing non-communicable diseases and injuries: Major challenge to sustainable development in the 21st century” held in Doha, Qatar, on 10-11 May 2009, examined the global and regional magnitudes of non-communicable diseases (NCDs) (cardiovascular disease, cancers, diabetes and chronic respiratory diseases) and injuries (caused by traffic crashes, burns, falls, drowning or violence), the social economic impact at macro-economic and household levels in low- and middle-income countries, solutions to address common modifiable risk factors, and how to integrate the care of these diseases and injuries into primary care. NCDs account for 60 per cent of all deaths globally and, when taken together with injuries, are responsible for 70 per cent of all death, with 80 per cent of them occurring in low- and

middle-income countries. H.E Mr. Abdullah bin Khalid Al-Qahtani, Minister of Health of Qatar, presented the following recommendations:

- Include NCDs and injuries, which account for one-third of poor people who die prematurely, into the core monitoring and evaluation system of the MDGs during the 2010 September Summit taking stock of the progress made towards the MDGs;
- Include NCDs in national development strategies and ensure adequate funding of these strategies. Today, less than 1 per cent of funds of international development agencies for improving health care outcomes is devoted to technical support to developing countries in addressing NCDs and injuries;
- Strengthen primary health care for people with NCDs and injuries and address the link with poverty;
- Reduce and prevent the level of exposure of individuals and populations to common risk factors for NCDs and injuries, tobacco use, unhealthy diets and physical inactivity; and
- Map NCDs and injuries and their risk factors and determinants.

The Latin America and the Caribbean Regional Meeting on “Progress in reduction of the HIV/AIDS pandemic and its interconnection with development”, held in Jamaica, on 2-6 June 2009, took stock of the progress made in controlling HIV in the region. It analyzed the main obstacles in making further progress in areas of prevention, treatment and care of HIV, towards the achievement of the HIV-related MDGs, especially in Latin America and the Caribbean region. Addressing HIV is central to public health, socio-economic development and human security and needs to be kept on the national and regional agenda. H.E. Mr. Ruyard Spencer, Minister of Health of Jamaica, presented the following recommendations to the Council:

- Intervene in support of human rights, including sexual rights and social justice programmes, in accordance with the legal framework of each country to address stigma, homophobia and discrimination;
- Develop a balanced approach to the HIV response that addresses the social, infrastructural and legal factors and barriers that underpin risk taking and vulnerability;
- Formalize the Inter-sectoral Working Group mandate in the Ministerial Declaration “Prevention through Education” adopted in August 2008, in Mexico, which has been tasked to monitor the recommendations and resolutions of the Declaration;
- Target investment to strengthen integrated public health systems and strengthen primary health care services among other interventions such as integrated community-based care, which are required to effectively scale up HIV treatment;
- Call on governments, labour and other partners to work together to develop and implement a comprehensive approach to HIV prevention in the workplace;

- Promote the active engagement of the mass media and civil society in the promotion and implementation of comprehensive sexual education, promotion of sexual health and prevention of HIV;
- Adopt interventions targeted, at most, at risk populations and address gender inequity across development programming, especially given the feminization of the epidemic;
- Provide health services, including access to counseling, testing and comprehensive clinical care for HIV, in settings free from discrimination and homophobia;
- Make antiretroviral drugs available to all at lower costs; and
- Base policy decisions and programmes on high-quality and timely research and strengthen surveillance systems.

The Africa Regional Meeting on “E-Health – use of information and communication technologies for health” held in Accra, Ghana, on 10-11 June 2009, examined the potential of e-health solutions to achieve the MDGs. It also explored how e-health can help overcome problems of infrastructure and shortages and inequitable distribution of health personnel. At the same time, it noted that Africa has made limited progress on e-health. E-health plans, policies, strategies level, ethical and legislative frameworks remained weak and integration into the mainstream of health care limited. H.E. Mr. George Sipa-Adjah Yankey, Minister of Health of Ghana, highlighted the following key policy recommendations:

- Develop a global framework to guide the development of regional - and country - specific policies on e-health, including standards for interoperability and integration;
- Undertake an inventory of e-health initiatives and design a common evaluation framework to be used across regions;
- Create a repository of information and knowledge on e-health initiatives to share best practices on a regular and systematic basis, and in this regard, make full use of existing mechanisms of international and regional organizations;
- Develop legal, policy and regulatory instruments for health data protection, ownership and access;
- Engage the private sector to develop appropriate infrastructure to support the effective deployment of ICT;
- Initiate steps to develop national strategic plans, standards and norms for e-health, in conformity with international standards and explore ways of integrating ICT training in the curricula of health training institutions;
- Establish centers of excellence in e-Health to train health professional and to reach a critical mass of experts in scaling up country-specific e-health initiative; and
- Strengthen and enhance public-private initiatives to promote multi-sectoral use of health platforms and solutions in an integrated manner.

Report of the Special Event on “Philanthropy and the Global Public Health Agenda”, New York, USA, 23 February 2009¹

By Dr. Jeffrey L. Sturchio
President and CEO
Global Health Council

At the Special Event on Philanthropy and the Global Public Health Agenda, more than 500 representatives from the private sector, philanthropic institutions, NGOs and academia participated in discussions with Members States and experts from the United Nations system on how to improve health outcomes for women and girls and how to raise awareness of the opportunities to prevent and treat neglected tropical diseases. Two facts show that these issues are of utmost importance:

1. According to 2005 data, more than 500,000 women continue to die every year of causes related to pregnancy and childbirth. This is the Millennium Development Goal (MDG) on which there has been the least progress.
2. More than 1 billion people throughout the world are affected by neglected tropical diseases, the control of which can help alleviate conditions that promote poverty.

As Secretary-General Ban Ki-Moon observed in his remarks at the Special Event, “Women are engines of development and drivers of improved health. Maternal health is a critical component of the well-being of any society.” But the statistics show clearly that there is still much work to be done.

The dialogue in New York concluded that there is a clear need for a broad global initiative with a common framework to bring all stakeholders together to improve health outcomes for women and girls. Existing frameworks – the Cairo Programme of Action, the Beijing Platform, Countdown 2015 – offer important points of departure for coordinated actions to implement what we know will reduce maternal and child mortality dramatically. To address the magnitude of the need, there is an opportunity through enhanced incentives to catalyze corporate involvement in the cause, bringing the experience, knowledge, capacities and resources of the private sector to bear on the challenges ahead. The roles of philanthropy, NGOs and local associations were also recognized during the dialogue. For example, the Partnership for Maternal, Newborn and Child Health is supporting capacity building among health professionals to contribute to achieving MDGs 4 and 5, and the Global Health Council has worked with leaders from the maternal, child and reproductive health communities to develop a global Global Family Health Action Plan to accelerate progress on MDGs 4 and 5. Based on the successful examples of international mobilization in the fields of HIV/AIDS, malaria and other diseases, partnerships among key actors in the philanthropic, corporate, NGO and public sectors will be important resources in scaling up the response to maternal and child health and improving health outcomes for women and girls significantly by 2015.

There are some 1.2 billion people living on less than two dollars per day. Many of these individuals are also at highest risk of contracting one or more neglected tropical diseases (NTDs), parasitic and bacterial infections that not only kill some 500,000 people annually, but also stigmatize, disable and inhibit millions more from caring for themselves or their families. Controlling NTDs, as the report states, is “an untapped development opportunity to alleviate poverty in the world’s poorest populations, based on the availability of effective, low-cost tools – such as safe donated drugs, proven control strategies, a high return on investment and a solid track record of success.”

Participants agreed that partnerships have provided an important mechanism to address global public health challenges in this area, both to make existing drugs broadly available among affected populations and to search for new treatments. Success at scaling up these programmes will depend on mobilizing broader development resources – e.g. proper delivery systems, locally trained staff, coordinated supply chains – and on integrating these efforts more fully in national health systems. Finally, there was a call for more research on implementation, monitoring and evaluation of successful programmes and on how to ensure effective coordination of efforts to avoid fragmentation.

In his special keynote address, President Bill Clinton reinforced the importance of strengthening health systems for making continued progress on maternal and child health and NTDs and called for continued engagement by the philanthropic community and the private sector, even during the financial crisis, because “working in the poorest countries in the world is the least expensive thing we can do to fulfill our responsibilities as global citizens.”

Among the conclusions and next steps were recommendations:

- to scale up community and mid-level health workers;
- to build a global partnership or business coalition for maternal and child/girls’ health to guide corporate and philanthropic involvement in women and girl’s health initiatives;
- to devise new intellectual property management policies to encourage needs-driven research and development for new tools to attack neglected tropical diseases – as well as technology transfer of these tools to developing countries;
- to create a network of partnerships on neglected tropical diseases;
- to create a global fellows programme to provide for secondment of trained medical and business personnel to country programmes; and
- to implement periodic dialogues under ECOSOC auspices to coordinate the response of various NGOs, private sector and philanthropic organizations to the challenges of achieving key MDGs.

A detailed informal summary of the meeting and its recommendations has been published and is available at:

<http://www.un.org/ecosoc/julyhls/pdf/Philanthropy%20Brochure%20Final.pdf>

Report of South Asia Regional Meeting: “Financing strategies for health care”, Colombo, Sri Lanka, 16-18 March 2009²

By Dr. H.A.P. Kahandaliyanage
Secretary
Ministry of Healthcare & Nutrition
Sri Lanka

It is pertinent that the 2009 Annual Ministerial Review (AMR) focuses on the implementation of the commitments in the health sector, the subject of three MDGs. Sri Lanka, despite relatively limited resources, has many experiences, lessons and successes to share in this area. As a result of its commitment over several decades towards human development and social progress and targeted policy interventions, Sri Lanka is well on track to achieve the health-related MDGs.

It was against this background that Sri Lanka had volunteered to contribute to the 2009 Ministerial Review process by hosting the South Asia Regional Preparatory Meeting on Financing Strategies for Health Care, on 16-18 March in Colombo. The meeting was hosted by the Government of Sri Lanka, in collaboration with the United Nations Department of Economic and Social Council and WHO. 121 delegates attended the meeting, including several at the ministerial level. A wide spectrum of stakeholders participated - senior Government representatives, United Nations entities, financial institutions, funding agencies, regional organizations, civil society, private sector and academia.

The agenda of the meeting included four substantive sessions: (1) Financing strategies for healthcare including external financing; (2) Health systems in crisis situation; (3) Initiatives and recommendations presenting best practices and new initiatives; and (4) Progress in achievement of the MDGs. The opening session was addressed by the Minister for Foreign Affairs of Sri Lanka, Hon. Rohitha Bogollagama, and the Minister for Health care and Nutrition, Hon. Nimal Siripala de Silva. The keynote address was delivered by the Prime Minister of Sri Lanka, Hon. Ratnasiri Wickramanayaka. Opening remarks were also made by Mr. Thomas Steltzer, Assistant-Secretary-General, UNDESA and Mr. Anarfi Asamoah-Baah, Deputy Director-General, World Health Organization. The Vice-President of the Economic and Social Council, H.E. Ambassador Hamidon Ali, Permanent Representative of Malaysia to the United Nations in New York, also addressed the opening session.

Discussions took place against the backdrop of a worsening international economic and financial crisis and other crises which affect progress in the achievement of the MDGs, including in the health sector. The Asian region is very diverse and national health expenditures vary significantly. Solutions to challenges in the health sector need to be geared towards special needs and particular circumstances of each country. The participants examined key challenges that countries, particularly low-income countries,

face in financing their health systems in the process of achieving the Internationally Agreed Development Goals on global public health. They discussed how the international community can support countries, as they move towards universal coverage by: (a) increasing funding in health; (b) making it more predictable; (c) channeling funds to recipient countries in ways that strengthen national financing systems; and (d) better financing of health in crisis situation. While civil society and the private sector have important roles to play, the public sector has to take the lead role to deliver effective and equitable health services. Public-private partnerships are central for achieving the desired outcomes.

The key messages that emerged from the discussions were as follows:

- With regard to domestic sources of health care financing, for universal coverage to be achieved, there is a need to find increased domestic funding and enhance efficiency in the use of resources. Equitable access to health care requires a move away from out-of-pocket payments to other options. Even though national growth rates were reduced against the current global background, rising incomes provide an opportunity in many Asian countries to expand domestic health funding.
- With regard to external sources of funding, it was agreed that this needs to increase and become more predictable and better aligned with national priorities. Innovative sources for health financing should be additional and not a substitute for external ODA funding. Donors' tendency to focus on particular countries while neglecting others is to be avoided.
- With regard to health care in conflict situations, improving health care is possible even when countries are facing crises. Expenditure on health care should be on par with other areas in the recovery and rehabilitation phases.

Asia and Pacific Regional Meeting: Promoting Health literacy, Beijing, China, 29-30 April 2009³

By H.E. Mr. Chen Zhu
Minister of Health
China

The Chinese Government organized the Annual Ministerial Meeting of Asia-Pacific region on Promoting Health Literacy in Beijing, from 29 to 30 April, 2009. 13 health ministers out of 24 countries of the Asia-Pacific region and more than 110 representatives from various stakeholders, including eight United Nations and relevant regional organizations, 14 domestic organizations, as well as domestic and foreign academic institutions and non-governmental organizations, attended the meeting.

The Conference had four items on its agenda: (1) challenges facing health literacy in Asia-Pacific; (2) promoting cross-departmental cooperation and action; (3) the role of media and empowerment in the promotion of health literacy; and (4) enhancing capacity-building of health literacy. During the two-day meeting, representatives of various countries conducted a wide range of exchanges on health literacy. There were extensive discussions on the definition and connotation of "health literacy" and its significant impact on the achievement of the health-related development goals.

Health literacy refers to an individual's "ability to gain access to, understanding and use of, health information" for promoting and maintaining health. It describes "the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions".

Delegates agreed that improving health literacy is one of the most effective weapons in the prevention of chronic non-communicable diseases and infectious diseases, including A/H1N1 influenza. Furthermore, health literacy plays a key role in achieving the public health related Millennium Development Goals (MDGs).

The delegates also shared successful practices and experiences in improving health literacy carried out by governments, international organizations, non-governmental organizations and the private sector. The discussion covered a wide range of issues, including the understanding of the concept of health literacy in different countries, health literacy status quo, method of measurement of health literacy, intensifying policies, measures and capacity building of health literacy, the importance of cross-departmental cooperation, and the applications of the private sector, the mass media and information technology. Challenges and countermeasures were also discussed.

The conference reached following consensus:

First, health is a basic human right. Promoting health literacy is a fundamental cost-effective strategy of disease prevention, effective utilization of health services, improvement of primary health care and national health level, and promoting social

development. At present, the Asia-Pacific population, as a whole, have relatively low levels of health literacy. Therefore, there is a need to adopt more effective intervention measures, carry out activities to promote health literacy and strengthen capacity building of the sustainable development of health literacy promotion in a bid to enhance the health literacy of residents from various countries and regions, which is the foundation and an important guarantee for the achievement of the MDGs.

Second, promotion of health literacy is an important responsibility of the government. At the same time, multi-sector participation, coordination and cooperation are needed for effective implementation. Consequently, to strengthen capacity building of health promotion and carry out health literacy promotion activities, it is indispensable to establish partnerships among the relevant government departments, agencies, NGOs, private institutions, enterprises, media and civil society groups. The role of medical and health institutions and professionals should be given full attention. In addition, full use should be made of media and information technology to disseminate health knowledge and mobilize the masses to participate. The mass media can play a positive role in promoting health literacy.

Third, concrete measures to promote health literacy should be based on the social and cultural backgrounds of the country, guided by a "people first" principle, and put into action. As different countries and regions have their specific levels of socio-economic development and culture, international and inter-regional exchanges, dialogue and cooperation shall be strengthened on the basis of fully respecting different cultures. Additionally, attention needs to be accorded to the carrying out of community-based actions to promote health literacy, with particular emphasis on the promotion and enhancement of women's health literacy.

Lastly, global, regional and national action plans should be formulated at the earliest date. The connotation, measurement methods and indicators of health literacy should be defined, and an evidence-based approach to planning and implementing projects and activities to promote health literacy should be scaled up.

Overall, the Ministerial Conference served as a platform for exchanges and cooperation on health literacy for the Asia-Pacific nations, and played a constructive role in facilitating governments and international organizations to develop and improve health literacy action plans.

Western Asia Regional Meeting: Preventing and Controlling Non-Communicable Diseases, Doha, Qatar, 10-11 May 2009⁴

H.E. Mr. Abdullah bin Khalid Al-Qahtani
Minister of Health
Qatar

H.E. Abdullah bin Khalid Al-Qahtani, Minister of Health of Qatar, reported on the meeting that much more must be done to help save and improve the lives of millions of people and their families in the West Asia region and the whole world by addressing heart diseases, strokes, diabetes, cancers, and asthma, as well as injuries, in general, including road traffic crashes.

The meeting in Qatar also witnessed how policymakers in the West Asia region are coping with the challenge of formulating more effective strategies for preventing these non-communicable diseases (NCDs) and injuries. One of the key issues identified during the meeting was that the requests of many countries for technical support in strengthening national capacities to address the NCDs and injuries remain unanswered by the international development community because these problems have not been included in their development priorities, despite the fact that they have enormous negative impacts on low- and middle-income countries and are beyond the targets of the Millennium Development Goals (MDGs). In looking for ways to overcome this impasse, the participants adopted the Doha Declaration on Non-communicable Diseases and Injuries. The Declaration calls for the inclusion of NCDs and injuries in the global discussions on development, in order to save and improve the lives of millions of people, as part of the international community's efforts to put an end to poverty in 2015.

It is now time to start listening to the evidence and no longer to be guided by mistaken beliefs. Four important points that had been included in the report of the ECOSOC Ministerial Regional Preparatory meeting on addressing NCDs and injuries should be highlighted.

Firstly, the report estimates that in the Middle East, almost one million people die prematurely every year from preventable heart diseases, stroke, diabetes, cancers and asthma, as a part of increased exposure to modifiable risk factors for NCDs and weak primary health care services, which do not respond efficiently and equitably to the healthcare needs of people with NCDs. Furthermore, another half a million pedestrians, motorcyclists, cyclists, and drivers die every year in the Middle East as a result of road-traffic crashes as well as of inadequate legislation to protect people, all of those not being enforced and emergency trauma care services being inadequate. The World Health Organization projects that the numbers of deaths from NCDs will increase in the Middle East by 25 per cent before 2015, the target date for the achievement of the MDGs.

The relevance of NCDs and injuries to the Economic and Social Council arises from the known and potential linkages with poverty, health and economic losses of the West Asia population, including those on working age and the demands they place on budget.

The cost of caring for a family member with diabetes in countries like Sudan is equivalent to 23 per cent of a low household income. The poorest households are spending more than 10 per cent of their income on tobacco products. The challenges policymakers in the West Asia region face include how to address these links between poverty and NCDs and injuries, how to minimize the health and economic losses among the economically-active population, and how to prepare for the pressure on health systems resulting from these growing numbers of people with these conditions.

Secondly, the report shows that premature deaths and chronic poverty traps from NCDs and injuries could be prevented through substantial interventions, including: reducing the level of exposure to individuals and populations to common risk factors for NCDs and injuries, tobacco use, unhealthy diet, absence of physical activity need to be urgently reduced and prevented.; strengthening primary care for people with NCDs and injuries; and mapping the epidemics of NCDs and injuries, their risk factors and their determinance.

Reports also cite abundant examples of successful approaches in the countries of the Middle East and other regions which have piloted these proven interventions. While many governments have expressed their intention to scale up these pilots, yet, the many complementary institutional reforms and upstream investments required to sustain such efforts are not part of national development strategies influenced by the prevailing global development assistance architecture. As a result, people are denied access to life-saving interventions.

Thirdly, the report also shows why NCDs and injuries should no longer be excluded from global discussions related to development. Health issues currently included under the MDGs address two-thirds of premature deaths among the poorest people in developing countries. One-third of poor people who die prematurely from NCDs and injuries are not covered by the MDGs. Poverty reduction is the central mission of the World Bank, the United Nations agencies, bilateral donors, foundations, and philanthropic organizations. Looking at NCDs and injuries through that perspective is essential. Yet, international agencies are missing in action in terms of responding to the requests from low- and middle- income countries to provide support to strengthen national capacities to address these emerging public policy issues. This can be illustrated by the following example. In 2006, the international development agencies allocated the sum of \$21 billion to improve public health outcomes in developing countries. Of this amount, less than 1 per cent was allocated to provide technical support to developing countries in addressing NCDs and injuries, which are responsible for more than 25 million deaths each year in developing countries. This is the essence of the argument put forward by the participants of the meeting. If no action is taken by rich countries to pledge support to low- and middle-income countries in addressing NCDs and injuries, then the burden of long-term care on households, health systems and budgets could seriously derail efforts to put an end to poverty by 2015 and to achieve the MDGs.

Finally, the report makes two concrete recommendations for consideration during this high-level dialogue to get beyond this impasse. The Doha Declaration on NCDs and injuries adopted at the meeting calls for the integration of indicators on NCDs and injuries into the core monitoring and evaluation system of the MDGs during the 2010 MDGs Review Summit. The participants also recommend that the Economic and Social Council consider the issue of prevention of NCDs and injuries at its high-level segment of 2010.

NCDs and road traffic accidents, long considered the companions of affluent societies, now impose their greatest burden on low- and middle-income countries. NCDs account for 60 per cent of all deaths globally and, when taken together with injuries, they are responsible for 70 per cent of all deaths globally, with 80 per cent of these deaths occurring in low- and middle-income countries. About half of these deaths caused by NCDs are premature. Policymakers in low- and middle-income countries and other countries outside the Middle East are similarly faced with challenges on how to formulate affordable strategies to reduce the level of exposure to risk factors of NCDs, to strengthen primary health care for people with these diseases, and to address the links with poverty.

The Caribbean Heads of Government in the Nassau Declaration of 2001 already emphasized that NCDs are one of the major health problems. The Heads met again in Port of Spain in September 2007, in a special summit to discuss NCDs and were so taken by the magnitude of the problem and its socioeconomic impacts on the region that they pledged to reduce the level of exposure to common risk factors and to invest in primary health care to address this problem. Rich countries have not yet pledged to support them, and the call from low and middle-income countries for help to improve the lives of people and their families has not been acknowledged by the international community, as these problems have not yet been included in the global discussions on development. As the Director of the WHO recently stated, commitments of official development assistance for health have more than doubled. Health has never before enjoyed such attention nor benefited from such wealth. No one wants to see this momentum weaken or falter, but it is definitely under threat if the international community does not address the needs of one-third of the poorest people who die as a result of NCDs and injuries. There is a clear call from low- and middle-income countries to no longer exclude NCDs and injuries in global discussions on development. These calls are heard very clearly from leaders within and beyond the Middle East to include these needs in the MDGs, to give them a moral dimension and to invest in them with social values, like a poverty reduction strategy. The MDG Review Summit in 2010 constitutes a powerful instrument to operationalize this call.

Latin America and the Caribbean Regional Meeting: Progress in Reduction of the HIV/AIDS Pandemic and its Interconnection with Development, Jamaica, 5-6 June 2009⁵

By H.E. Mr. Rudyard Spencer
Minister of Health and the Environment
Jamaica

The meeting took stock of the progress made in controlling HIV in the region, analyzed the main obstacles in achieving further successes and discussed ways of making further advances in the prevention, treatment and care of HIV, towards the achievement of the HIV-related Millennium Development Goals (MDGs). 103 participants from international, regional and non-governmental organizations and the private sector were in attendance. The meeting was organized around four panel discussions on the following themes:

- Challenges of HIV as a development concern and the Latin American and Caribbean response;
- Challenges and solutions in the response to HIV in Latin America and the Caribbean in reaching universal access goals;
- Presentations of best practices and policies in response to HIV in the region; and
- Implication of the global financial crisis for HIV and health.

Four key messages emerged from the presentations and discussions:

- Addressing HIV is central to public health, socio-economic development and human security;
- The region must provide renewed leadership and keep HIV on national and regional agendas;
- Prevention of HIV infection is a critical component in halting and reversing the HIV epidemic; and
- Urgent and increased investments and interventions are needed in support of human rights, including sexual rights and social justice programmes, in accordance with the legal framework of each country to address stigma, homophobia and discrimination.

A clear consensus of the participants is that future response to the epidemic must involve a multi-sectoral approach, including the labour sector, in order to address the social determinants of the epidemic. There was a call for closer collaboration between the health and education sectors to address the needs of young people. The delegates also agreed to formalize the inter-sectoral working group as mandated in the Ministerial Declaration

"Preventing through Education," adopted in August 2008, in Mexico. The Working Group has been mandated to monitor the recommendations and resolutions of the Declaration.

The following recommendations were made by the participants during the meeting:

- Member States should establish an inter-sectoral working group to monitor the implementation of the commitments made in the Ministerial Declaration adopted at the 17th International Aids Conference in August in Mexico;
- Governments need to develop a balanced approach to the HIV response that addresses the social, infrastructural and legal factors and barriers that underpin risk taking and vulnerability;
- Investments should be targeted to strengthen integrated public health systems;
- Government, labour and other partners must work together to develop and implement a comprehensive approach to HIV prevention in the workplace;
- The strengthening of primary health care services among other interventions, such as integrated community-based care, is required to effectively scale up HIV treatment;
- Governments must promote the active engagement of the mass media and civil society in the promotion and implementation of comprehensive sex education, promotion of sexual health and prevention of HIV;
- Gender inequality needs to be addressed across development programming given the feminization of the epidemic;
- Most-at-risk populations require targeted interventions, including outreach services and improved access to basic sexual health services;
- Health services must be provided in settings free from discrimination and homophobia and should include access to counseling, testing and comprehensive;
- Clinical care for HIV positive patients;
- Antiretroviral drugs should be made available to all at lower cost; and
- Policy decisions and programmes must be based on high quality and timely research. Surveillance systems should be strengthened to capture where new cases are coming from and project where they are likely to arise.

Report of the African Regional Meeting: eHealth – Use of Information and Communication Technologies for Health, Accra, Ghana, 10-11 June 2009⁶

By H.E. Dr. George Sipa-Adjah Yankey,
Minister of Health
Ghana

The meeting of African Health Ministers held in Accra, Ghana, from 10 to 11 June 2009, considered the presentations, views and comments by representatives of governments from the African region on the use of information and communication technologies (ICTs) for health. The meeting also heard from experts from the United Nations system and other international organizations, academia and the private sector and noted the overwhelming consensus on the potential impact of electronic health solutions on health care delivery in both developed and developing countries and in accelerating the achievement of the MDGs.

Participants agreed that while significant developments have, and continue to, take place in the application of ICTs in health, there still remain challenges in the area of eHealth governance, policies, strategies and quality measures that will assure countries, particularly in Africa, of sustained and targeted investments in the health sector.

It was agreed that when systematically implemented, eHealth would help solve some of the problems of underdeveloped infrastructure, shortages and inequitable distribution of health personnel in many developing countries. It will also help empower people by improving access to knowledge that will enable them to access services and make healthier lifestyle choices.

In addition, the application of eHealth, has the potential for vast improvements in both management and technical efficiency of health workforce at all levels through reliable information dissemination systems and by supporting the decision making process.

Participants were concerned that despite these potentials, eHealth activities have not been integrated in health systems development with many initiatives still follow a vertical approach and have been in pilot phases for very long periods. In Africa, especially, it was observed that national eHealth plans, policies, strategies, legal, ethical and legislative frameworks have remained very weak, leading to minimal progress in effective development and integration into mainstream health care.

The importance of standards and interoperability was underscored for the effective delivery of e-health services. The meeting recalled that WHO had established an e-health Standardization Coordination Group as a platform to promote stronger coordination among the key players and called on countries to engage actively in this effort and in other processes for setting international standards.

The meeting observed that financing eHealth infrastructure and services required strong collaboration between the public and private sectors and concerns were raised over the inadequate medium- to long-term investment plan in developing countries. This notwithstanding, the forceful emergence of mobile telephony and its rapid diffusion into rural areas was seen as a huge e-health asset for cost-effective expansion of health services, especially in developing countries.

The difficulty in data communication and integration of solutions and the cost involved in the use of proprietary solutions were noted as were as the need for increasing commitments towards adopting Open Source software technology that is both sustainable and flexible.

The meeting urged the Economic and Social Council, in collaboration with WHO and other United Nations organizations to:

- Develop a global framework to guide the development of regional and country-specific policies on eHealth including standards for ensuring interoperability and integration;
- Undertake an inventory of eHealth initiatives and design a common evaluation framework, in order to share lessons from different parts of the world. Lessons from implementation of large-scale projects should be shared on a regular and systematic basis, using existing mechanisms of international and regional organizations; and
- Create a repository of information and knowledge on e-health initiatives to share best practices.

The meeting also urged countries to:

- Develop legal, policy and regulatory instruments for health data protection, confidentiality, ownership and access;
- Engage with the private sector to develop appropriate infrastructure to support the effective deployment of ICTs for a sustained implementation of e-health solutions;
- Initiate steps to develop national strategic plans, standards and norms for eHealth in conformity with international standards and to explore ways of integrating ICT training in the curricula of health training institutions;
- Establish centres of excellence in eHealth to train health professionals and to reach a critical mass of experts in scaling up country specific eHealth initiatives; and
- Strengthen and enhance Public-Private Partnerships to promote multi-sectoral use of m-Health platforms and solutions in an integrated manner.

African Ministers present at the meeting expressed the need to ensure that the adoption of eHealth solutions does not create a new divide between the developing and developed world, but rather to focus on enhancing the capacity of developing countries to improve the health status of their population and to protect the human capital to sustain growth and development.

PART B - 2009 ANNUAL MINISTERIAL REVIEW

NATIONAL VOLUNTARY PRESENTATIONS OF BOLIVIA, CHINA, JAMAICA, JAPAN, MALI, SRI LANKA, SUDAN

Overview

Since 2007, the Economic and Social Council annually performs a Annual Ministerial Review (AMR) of the implementation of the internationally agreed development goals (IADGs), including the Millennium Development Goals (MDGs). One pillar of the AMR focuses on country specific case studies, which are based on National Voluntary Presentations (NVP) by a selected group of countries.

NVP serves as a critical forum for a dialogue based on countries' experiences in implementing strategies and policies towards meeting the MDGs. In their presentations, countries show strategies and policies that have worked and those that have not, and identify practical measures to respond. The presentations are based on an analytical national report and national consultative dialogues. Each year, approximately eight to ten countries make a presentation.

NVP links the discussion of policy options to specific country experiences resulting in a more specific and hands-on approach and bringing the Council closer to bridging the divide between the normative and operational work of the United Nations.

The objective is to speed up the implementation of development goals by strengthening accountability for commitments; providing a vehicle for a national review and renewal of commitments; encourage policy dialogue; encourage capacity building; and mobilizing actions and stakeholders.

NVP not only serves to strengthen policy coherence (the horizontal coordination) at the intergovernmental, inter-agency and country levels, but also establishes a link between policy and operational activities (the vertical coordination).

This year, seven countries made NVPs: Jamaica, China, Japan, Bolivia, Mali, Sri Lanka and Sudan, in the order of presentation. Through the national presentations, each year, countries volunteer to share their development experience with the rest of the world during the high-level segment of the annual session of ECOSOC. These presentations enable the Council to engage in a much more specific and hands-on debate on how to address the key obstacles to the implementation of the national development strategies.

NVPs, coupled with the database which presents “Development Strategies that Work”, provide an important opportunity to learn about, and benefit from, the experiences of the countries facing similar challenges. The following provides highlights of the 2009 presentations:

Jamaica presented the case of, a middle-income, small island developing state. Its major sources of income are tourism and bauxite. In time of global recession like at present, the economy feels the impact severely. Yet, because of its middle-income status, it is hard to

receive external support. Jamaica highlighted the progress made in the fight against HIV/AIDS. However, it underscored the issue of non-communicable diseases (NCDs) and proposed a special session of the United Nations General Assembly on NCDs and to include them as a target in Goal 6 at the 2010 Summit.

China pointed out that the major cause of poverty in the country was ill health and the Government had stepped up measures to improve health and nutrition. Health services and health technologies have been greatly enhanced. Recently, China made contributions to the global prevention and control of H1N1 through international exchanges and assistance by providing diagnostic services, training and personnel to countries in need, such as Mexico. China had in place a major health programme of 850 billion Yuan, as part of the stimulus package to the financial and economic crisis. As one of the remaining challenges, the disparity between rural and urban areas was highlighted. Over the next three years, China's priority would, therefore, be to increase coverage of health services in rural areas.

Japan stated that it has been an active player in the field of global health. At the G8 Kyushu Okinawa Summit in 2000, Japan took up the issue of infectious diseases and announced the Okinawa Infectious Diseases Initiative, which led to the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2002. At the Fourth Tokyo International Conference on African Development (TICAD IV) and again at the G8 Hokkaido Toyako Summit last year, Japan emphasized the importance of a "comprehensive approach", which mutually reinforces the vertical, disease-specific approach and the horizontal, health systems strengthening approach. Japan noted that it invited all relevant stakeholders to participate in the formulation of the "Toyako Framework for Action". Two examples of their development cooperation projects were presented. One is on tuberculosis (TB) control in Cambodia, which employs a comprehensive approach based on health systems strengthening. Another is a health capital investment plan support in Zambia. Japan explained that it is currently following up on its commitments announced at TICAD IV by training 100,000 health and medical workers in Africa. Japan has also disbursed approximately US\$ 4.6 billion in total to the Health and Development Initiative (HDI). The initial pledge of US\$ 5 billion over five years will be almost realized in just three years. In addition, Japan has disbursed, as of today, US\$ 1.04 billion to the Global Fund.

Bolivia emphasized that since 2006, it has implemented numerous socially inclusive policies. Because of the nationalization of the oil and natural resource companies, government revenue has increased, which forms the bases of public investment and the social policies. A number of innovative policies have been introduced: bonds to increase school retention, a pension scheme for retirees from bankrupt companies, programmes to alphabetize people, improvement of maternal and child health, and eye surgery to improve or restore eyesight. These have already showed significant results. Bolivia identified the current financial and economic crisis, as well as the need to accelerate the pace of progress as their two challenges in their efforts to achieve the MDGs.

Mali presented the case of a least developed, landlocked, African country. It has identified progress in a number of areas, including poverty reduction and primary education. But they emphasized that progress is fragile. Within health-related MDGs,

there is some tangible progress in halting HIV/AIDS and improving access to health services. However, maternal and child health remain a major concern of the country. Mali's NVP Friends praised the country's frank and pragmatic approach and assured their continued support to the effort of Mali towards achieving the MDGs.

Sri Lanka presented the case of a country in a post-conflict context. After almost three decades of confronting terrorism, it had now put in place a supportive framework of social determinants for health. Sri Lanka had systematically invested funds to develop human and physical resources in the public health care sector, and health care services had been provided free of charge and within facilities located close to clients. Infant mortality had declined, placing Sri Lanka on track to achieve that MDG target in 2015. The maternal mortality rate was also likely to decline by 2015, thus also reaching the Goal target, and Sri Lanka was confident of completion of malaria eradication by 2015.

Sudan presented the case of a developing country that has been afflicted by conflict, which, in turn, has dramatically diminished its opportunities for development. Poverty affected 50 to 60 per cent of the population in the North and more predominantly in the South of the country. Child mortality rates were alarming. Sudan, therefore, stressed that without peace there could be no health services, or development. Sudan had been committed \$4.8 billion in aid, but had not received more than \$30 million, disbursed by the various financial institutions, as part of the Highly Indebted Poor Countries initiative. In the area of health, there were only 1.5 health care providers for every 1,000 people in Sudan. That affected the distribution of health services, which were markedly unequal. Particularly noteworthy was Sudan's basic nutrition plan, the nutrition emergency package, and the food fortification strategy.

Jamaica⁷

Jamaica showed mixed results in the achievement of the MDGs. Jamaica has achieved the goals for reduction in absolute poverty, reduction in hunger and universal access to primary education and is on track to achieve universal access to reproductive health, to halt and reverse the spread of HIV/AIDS, malaria and tuberculosis, and to achieve universal access to potable water and basic sanitation.

A major area of success is in addressing the HIV/AIDS pandemic. While there is room for improvement in tackling stigma and discrimination, significant inroads had been made in increasing access to antiretroviral drugs, resulting in a significant reduction in mother-to-child transmission and deaths due to AIDS. As the prevalence of chronic non-communicable diseases (NCDs) presents new challenges to public health, Jamaica recommended that ECOSOC place before the United Nations General Assembly a new target relating to halving the incidence of chronic NCDs by 2015, and a new target pertaining to the prevalence of chronic NCDs by sex and age. Jamaica also recommended that more health-related development aid be made available to those countries that were heavily indebted, especially in light of the global recession.

Jamaica is developing a new primary health care strategy to meet challenges of sustainability, cost-effectiveness and quality. Strategies for renewal included (1) innovative health financing, (2) infrastructure upgrading, (3) improved information systems, better-trained leadership and managers, and (4) community empowerment. The National Health Fund is a government agency that was established in 2003, making Jamaica the first country in the world to have an innovative health fund. It is financed through taxation of cigarettes, and the main focus is the provision of individual benefits, presently by way of pharmaceuticals.

The greatest long-term challenge in meeting the MDG targets is the debt burden, which was the fourth highest in the world, and makes it almost impossible to make significant headway in meeting development obstacles. Other challenges were the significant quality and equity issues in early childhood and primary education, including low rural attendance. While there is a high level of unemployment among women and low levels of representation, there is also underperformance by males at all levels of education, and thus both aspects of gender need to be addressed. Jamaica is also far behind in reduction of child and maternal mortality. Shortage in midwives has negatively impacted resources. While maternal deaths from direct causes were halved, deaths from indirect causes have increased. There is also slippage in achievement of significant improvement in the lives of slum dwellers.

More development aid is needed to prevent reversal of many MDGs. Main policy interventions are: (1) the renewal of primary health care and, in particular, the upgrading of infrastructure, the re-engineering of human resources and improved information systems; and (2) the abolition of user fees at public health facilities.

China⁸

China has made great strides towards eradicating hunger and poverty, combating malaria and tuberculosis and reducing maternal mortality. The percentage of the poor has decreased from 10.2 per cent of the population in 2000 to 4.2 per cent in 2008, which means that China has met the poverty MDG already.

China conducted a study on the causes of poverty in the country, which showed that illness was a major factor. The Government has, therefore, taken measures to step up its response in health and nutrition. The health services and technologies have been greatly enhanced. Major diseases and endemic diseases have either been eradicated or brought under control. The under-five child mortality rate – 61 per thousand in 1991 – has decreased to 18.1 per thousand in 2007. China also made progress in reducing maternal mortality, which declined from 94.7 per 100,000 live births in 1990 to 34.7 per 100,000 live births in 2008. More needs to be done, however, to meet the MDG on maternal mortality.

In combating AIDS, malaria and other diseases, China has made good progress. Free treatment was provided for tuberculosis patients, with 100 per cent coverage. Since the severe acute respiratory syndrome (SARS) breakout in 2003, the Government has strengthened the public health system response mechanisms and emergency response networks. Joint actions and coordination at the international level have been greatly improved as well. With the outbreak of H1N1 flu, China has adopted effective measures to slow down the import, spread and prevalence of the disease nationwide, which has gained time to prepare for a more serious potential outbreak and to stockpile vaccines and drugs. 1,114 cases of H1N1 have been recorded and no critical cases or deaths reported. Furthermore, China has made a contribution to the global prevention and control of H1N1 through international exchanges and assistance by providing diagnostic services, training and personnel to countries in need. China believes that it is important to put people at centre stage, as their health is the basis to social and economic development.

China is confronting challenges. Five key tasks for 2008-2010 are (1) the improvement of grassroots medical and health service systems, (2) making primary public health services equally accessible for all, (3) expediting the construction of basic medical insurance systems, (4) establishing a national system of essential medicines, and (5) promoting reform pilot projects in public health. China is devoted to addressing the inequalities in income, social insurance, medical services and education and is actively involved in international cooperation to contribute to achieving the MDGs throughout the world.

Japan⁹

Japan attaches great importance to the issue of global health. In order to address global issues, such as terrorism, infectious diseases, environmental degradation, poverty and conflict effectively, Japan had promulgated the concept of human security, aimed to protect the vital core of all human lives in ways that enhance human freedom and fulfilment through protection and empowerment of both individuals and communities. Such a comprehensive approach was necessary, including a disease-specific approach involving all stakeholders.

Japan has learned a good practice in achieving prominent health goals through strengthening national health systems, such as the Tuberculosis Control through Directly Observed Treatment project in Cambodia. It has steadily fulfilled its commitments to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and is firmly implementing comprehensive health assistance programmes tailored towards achieving the health-related MDGs.

However, progress in achieving the health-related MDGs worldwide was lagging behind. If the current trends persist in sub-Saharan Africa, the prospect is that none of the health-related MDGs would be met. In the worst-case scenario, there would simply be no progress at all by 2015. Japan has, thus, committed itself to bringing this issue to the attention of the international community, raising it at international conferences. Japan was living up to its commitments by training thousands of health workers in Africa and placing special focus on health system development in its health partnerships with international organizations and bilateral partners.

All bodies, international organizations, the private sector and civil society, as well as others, should play their respective role in the field of health system strengthening. Namely, these efforts should be enforced through a participatory approach. As funding gaps should be filled, the financial crisis could be seen as a golden opportunity for the international community to distribute resources to their fullest potential and to those who need it most towards the achievement of the MDGs.

Bolivia¹⁰

For Bolivia, achieving the MDGs requires deep structural changes that had been included in the Constitution and the “Live Well” programme within the framework of the National Development Plan, with its four pillars: a dignified, sovereign, productive and democratic Bolivia to “Live Well”. This covers decent work, decent housing, adequate food, education, transport, electricity, water, and sewage systems.

Health is a key priority. The Government has begun to pay the mother-child voucher, “Juana Azurduy”, an incentive for safe motherhood and integral development of children from birth to two years of age. The voucher would cover 74 per cent of households that had no access to social security. In 2006, 545 new public health establishments had been created. The rate of extreme poverty has fallen from 41.2 per cent in 1996 to 31.8 per cent in 2008. There has been a decline in chronic malnutrition during the period 2003 to 2008 by 5.3 percentage points, reaching 20.3 per cent. Infant mortality has been lowered to 50 deaths per 1,000 live births. Pregnant women attended by health personnel had increased from 43 per cent to 64 per cent between 1998 and 2008.

In the area of education, the “Juancito Pinto voucher” programme is improving enrolment, retention rates, and the quality of education by providing incentives for children to be enrolled, attend and complete their primary school grades in public schools. With respect to illiteracy, the main action undertaken is the National “Yes, I can” Literacy Programme.

To improve nutrition, the multisectoral “Zero Malnutrition” Programme, focusing on children under five years of age and especially those under two years of age, gives priority to activities in the more vulnerable municipalities. The programme promotes the consumption of supplementary food for children aged 6 to 24 months, and the consumption of food fortified with micronutrients for pregnant women. The programme also encourages the immunization of children.

The external shocks in 2007 and 2008 had increased international food and energy prices and resulted in lower terms of trade for Bolivia’s exports, which limited its capacity to progress towards the MDGs. Mechanisms need to be put in place and agreed upon to prevent smaller economies from falling into the abyss of the crisis. Unless there is a global covenant to combat asymmetries, all efforts to progress towards the MDGs will be in vain.

Mali¹¹

In terms of human development, Mali is among the least developed countries. Between 1997 and 1999, a national study was conducted calling upon all Malians to describe their vision for Mali to be reached in 2025. That study provided a basis for the creation of strategic frameworks to combat poverty, improve governance and participation and to develop human resources and basic infrastructure.

With regard to the MDGs, success was achieved in many areas. Food security is ensured and malnutrition combated over the last decade through two programmes: “160 Communes Initiative”, aimed at addressing the needs of the most vulnerable communes in the country, and the “National Programme for Food Security”. With regard to ensuring primary education for all, the growth rate in 2008 has been 80 per cent, as compared with 77.6 per cent for 2006-2007 in Mali. The girl-boy ratio has gone from 68 for every 100 students in 2004 to 81 in 2008. This is the result of increased funding for educational development programmes.

Considerable challenges remain. The insufficiency of training for instructors, resources and facilities is a major challenge. The maternal mortality rates remain high, as there are between 500-600 deaths for every 100,000 births. Similarly, the child mortality rate is also still high. There is a slight decrease in HIV/AIDS prevalence rates. The constraints facing the Government in that area are based on the slowness of the transfer of resources to communities, the insufficient sanitary plans in some areas, non-coverage by communities, the absence of community law on health and the lack of access in some of the regions in the north of the country, as well as the lack of qualified personnel at all levels.

Promoting equality between men and women, in particular, by improving the level of literacy among women remains a concern. Mali has taken measures to give better access for women to microcredit and ensure equal access for women to Government, either by election or by appointment to public office. There is a funding gap of \$5.7 billion to achieve the MDGs. The Government expects to contribute 14 per cent, with another 13 per cent made up by donors to various development programmes and projects. Mali has urged international donors and partners to respect their commitments in ODA, in conformity with the Paris Declaration.

Sri Lanka¹²

Sri Lanka underlined that the realization of MDGs required global partnerships. This year's discussions at ECOSOC would make a constructive contribution towards realizing the health-related MDGs.

Sri Lanka was early among developing countries to invest in human resources, gender equality and social development. A large share of public expenditure was allocated over the years, even during almost three decades of confronting terrorism, to free education and health services, to the development of human and physical resources in the health-care sector, and to food subsidies and subsidized credit. Supported by high levels of literacy in society, there has also been growing awareness among the people about the benefits of good health. A large segment of the health care system integrated indigenous systems of medicine, focusing on both preventive and curative care.

The impact of policies on health care indicators has been impressive. Infant mortality has declined, placing Sri Lanka on track to achieve that MDG target in 2015. The health authorities were also confident of being able to achieve the maternal mortality target and complete malaria eradication by 2015.

A major challenge is to reach all social groups and, in that, many institutions other than those related to health care have to play a role in creating a supportive environment. The health care system currently operates under many stresses, as a result of the overall country situation in terms of macroeconomic, developmental, historical, social, political and legal conditions.

The principle lesson is that human development could be brought to high levels even at low levels of per capita income through systematic and well thought out interventions. This requires, however, strong economic growth and an enabling global environment.

Sudan¹³

Sudan is facing many great challenges which it has to meet at the same time. Sudan has sought to end the conflict in the country, as peace, security and stability were the foundation to achieve the health and development goals. The President has put an end to the war in the east of the country and in Darfur and tried to contain the effects of the conflict in the realm of health. As a result, there has been no health catastrophe in Darfur. Sudan's partners include the United Nations and the specialized agencies, which have made tremendous efforts to help the country to manage the post-conflict situation. Sudan has been promised \$4.8 billion in aid, but had not received more than \$30 million, disbursed by the various financial institutions, as part of the Highly Indebted Poor Countries initiative.

Challenges are: the size of the country- which borders on nine others- with generally free movement across, which has implications on health and development. There is massive population movement and displacement, mainly due to civil conflict and natural disasters. Moreover, there is also a high illiteracy rate, mainly among women, and low population awareness on health issues. The low number of health care providers is a concern, as there are only 1.5 care providers for every 1,000 people. There is also a high turnover, especially of doctors, which affects the distribution of health services that are markedly unequal.

Other challenges are low school attendance with only 53.7 per cent of school age children attending primary school, with disparities among states. The ratio of girls to boys is 93 per cent. Only 4 per cent of the population has a comprehensive knowledge as how to prevent HIV/AIDS. Only 55.1 per cent of the total population uses improved water sources or have access to them, and only 31.4 per cent have access to sanitary means of excreta waste disposal. The infant mortality rate is 80.7 out of 1,000 live births for the whole country. The maternal mortality ratio itself is one the highest in the world- 1,106.7 per 100,000 women of reproductive age on average.

Notes

- 1 From the 2009 ECOSOC high-level segment, 6 July 2009.
- 2 Ibid.
- 3 Ibid.
- 4 Ibid.
- 5 Ibid.
- 6 Ibid.
- 7 From the 2009 ECOSOC high-level segment, 7 July 2009.
- 8 Ibid.
- 9 Ibid.
- 10 Ibid.
- 11 Ibid.
- 12 From the 2009 ECOSOC high-level segment, 8 July 2009.
- 13 Ibid.

Chapter 4

PARTNERSHIPS IN HEALTH – LESSONS FROM MULTI-STAKEHOLDER INITIATIVES IN GLOBAL PUBLIC HEALTH

Overview

Over the last decade, global health partnerships have become a new approach to help scale up priority health interventions and investments around the world. In particular, the fight against HIV/Aids, tuberculosis, malaria, and obstetric fistula has benefited from partnerships in the past.

These partnerships need to be further developed, and organizations, governments and private actors should be encouraged to use partnerships as a platform for successful eradication of diseases in their efforts to strengthen health systems. In particular, in the time of global economic and financial crisis, there is a strong need to consider the economic value of partnerships in the health sector.

The international community should develop new sources of financing to help countries battle these diseases, and to strengthen national health systems. Partnerships could also be used to finance health delivery. Through innovative partnerships, appropriate prices can be set and more people can access high-quality health care.

The Millennium Development Goals (MDGs) continue to provide an excellent framework for partnership in health and between health and the broader development field. With only six years to go to the 2015 deadline for the MDGs, it is important to make partnerships in global public health work.

Partnerships to fight HIV/AIDS

In the fight against HIV/AIDS, partnerships are crucial. Worldwide solidarity has been developed and mobilized effectively and resources have been allocated to fight HIV/AIDS. Today, more than three million people are being treated in Africa. This demonstrates how global solidarity can produce concrete results. However, there is some concern about the medication used for the treatment of AIDS, since 94 per cent of the people treated in Africa are treated with outdated medication. The lack of access to appropriate medication for vulnerable populations is also a human rights issue. In addition, some 19 million people are still untreated in Africa. A nationalized response, along with a long-term investment, is needed, engaging all partners and donors to align priorities and activities. The response and coordination in the fight against HIV/AIDS shape the way UNAIDS and the Global Fund function. The HIV/AIDS movement has shown that public health requires the engagement and cooperation of all sectors of society. Responses to any major health challenge are most effective and durable, if based on collaboration rather than coercion, and it has contributed strongly to the idea that health products are not ordinary commodities but global public goods.

Partnerships to fight tuberculosis (TB)

Partnerships need to be strengthened to mainstream TB control within national health planning and primary health care systems. Research on a new vaccine is slowly moving forward. A new diagnostic test has been introduced in endemic countries, which can tell whether a person has drug-resistant TB in two days instead of three months previously. To conquer TB, there are several bottlenecks that must be addressed, among them, the financial difficulties for people who cannot afford to cover the charges for the drugs and the social determinants factored into TB.

Partnerships in the fight against malaria

The Roll Back Malaria partnership (RBM) has provided a coordinated global approach to fighting the disease. The RBM Partnership has agreed on a single road map for global malaria control and elimination around which all partners are aligning their work to achieve coordination and harmonization. The RBM has directly helped countries leverage unprecedented international funding to fight malaria. The malaria community has joined with others to develop integrated models for delivery of health services. In partnership with the Global Fund and UNITAID, RBM has taken forward an idea to make malaria medicines more effective. RBM supported a joint venture enabling technology transfer from Japan to Tanzania for the manufacture of state-of-the-art, long-lasting insecticide-treated bed nets. Partner support to deliver large-scale interventions has helped decrease malaria rates by more than 60 per cent in countries, such as Eritrea, Ethiopia, Rwanda, Swaziland, Zambia and Zanzibar.

The battle against fistula and partnerships

The partnerships to eradicate obstetric fistula are still lacking support at the national level. Fistula and maternal health must be addressed and integrated into the national public health care systems. A successful partnership between Virgin Unite, the United Nations Population Fund (UNFPA) and its Campaign to End Fistula has increased funding for the prevention and treatment of obstetric fistula. It has contributed to the health, economic and social well being of thousands of women in northern Nigeria. It has also helped to de-stigmatize obstetric fistula.

The financial crisis and innovative sources of funding

The worldwide financial stalemate is affecting international aid. Most donor countries are decreasing their level of international aid, falling short of \$50 billion that is urgently required to meet the current needs. New innovative, effective and sustainable sources of funding for health need to be urgently developed. One source of funding could be from tax payers. Or, some governments have introduced a tax on airline tickets, which is financing projects around the globe. In deciding the price of vaccines, it is also important to develop partnerships with citizens. Partnerships with pharmaceutical companies and investors, which could lower the cost of medication, are also important.

The Prominent Role of Partnerships in the Success of the AIDS Response¹

By Mr. Michel Sidibe
Executive Director
UNAIDS

The Economic and Social Council established UNAIDS as a new area of international governance to combat diseases that cross borders, through enhanced partnership. The establishment of UNAIDS and the fact that the fight against HIV/AIDS has been placed on all political agendas has ensured that the work to combat AIDS leads to results. The partnership has demonstrated that it is vital to produce results and to be effective.

The experience of the AIDS response has illustrated that, in order to fight against illness and to improve global health, there is political will behind. It has also demonstrated how the United Nations system can come together around a common cause. Communities and civil society have been at the heart of the global partnership for AIDS. In partnership, and with grass roots support, politicians and national leaders have helped to break down the conspiracy of silence, which has been a significant factor in making progress against the epidemic. Such partnership has helped to build worldwide solidarity to mobilize resources. Eight to nine years ago, there was hardly US 300 million to combat the AIDS pandemic; last year it was 14 billion. This proves that solidarity between the North and the South has been mobilized effectively to produce results which are visible and tangible.

Thanks to this mobilization and the support of the Global Fund to Fight AIDS, TB and Malaria and innovative financing mechanisms, 3000 people every day can be put on treatment. A few years ago, only 50,000 people were treated in Africa and, today, there are more than 3,200,000 on treatment. This shows that the global solidarity has already produced results. Still, the trajectory of the epidemic needs to be broken through prevention because for every two new people put on treatment, there are five new infections.

Ingredients of good partnership practice: lessons learned

The lessons that can be learned from the AIDS response over the past 25 years cover five major themes. Nationalized responses are crucial and must be based on a budget priority plan to align all partners, including donors' resources with the national priorities. Harmonization, reduction of duplication and results at lower costs are needed.

Predictable and sustainable financing is of critical importance. It is impossible to transform the fight against diseases, especially when they become complex global challenges, with budgets that span just two to three years. It is crucial to have long-term investment and planning, to help countries to transform their national response and make it more effective.

Progress is not possible without affordable commodities. Almost four million people are already undergoing treatment, while six million more are waiting for it, and we know that there are 22 million people infected with HIV in Africa. If we do not have a real debate on the price of drugs, most of those people will not have access to second and third line treatment. In Africa today, there are about 94 per cent of HIV positive people on treatment receiving outdated anti retro-viral drugs (ARVs), with a risk of developing resistance and endangering peoples' lives. So, the debate on trade is very important and AIDS has brought that debate to the forefront.

Health system and human resource capacity

AIDS has shown that there is a need to tap into non-conventional capacity, to mobilize all those on the ground who can expand health systems delivery, and reinforce the interface between providers of health care and communities by using the movement created by AIDS – the movement of millions of people who are changing the architecture of delivery systems.

It is important not to ignore the debate on human rights. Vulnerable groups would never have had access to services and resources had the AIDS response not provoked this debate—and demanded an end to discrimination.

Partnerships for the future

It is time to take AIDS out of isolation; time to build a new movement- an AIDS plus MDGs movement. This can not only create new synergies among all partners and players, but also leverage AIDS resources to produce broader health and development outcomes. It is not acceptable that, while the developed world has already virtually eliminated the vertical transmission of HIV from mothers to infants, there are more than 300,000 children still born with HIV every year in Africa. We need to build a new partnership to eliminate vertical transmission. Such a partnership will bring sexual and reproductive health, maternal and child health together with HIV, to create a new movement to transform the debate around global health and deliver results for people.

UNITAID: New Partnerships for Innovative Financing Mechanisms²

By Mr. Philippe Douste-Blazy
United Nations Special Advisor on Innovative Financing for Development
and Chair of the Board of UNITAID

With the financial crisis and just a few weeks away from the G-20 summit, a message should be sent that international aid has to be maintained on an ambitious scale. In 2000, we decided on the MDGs, and that we needed \$150 billion per year. We have \$100 billion in commitments today, and we need \$50 billion more. Most countries are stagnating their levels of development aid, and some are even decreasing them. This is a dramatic, tragic situation. But instead development aid should be increased.

President Lula once said: the largest nuclear weapons are hunger and poverty. I firmly believe this. President Lula in his address to the General Assembly in New York last September requested that, together with national budgets, new sources of funds, or innovative financing are needed. Where can this money be found? First of all, it has to come from politicians. For example, President Lula, President Chirac, President Lagos of Chile decided, together with Norway and the United Kingdom, to introduce a small tax on airline tickets. Because of initiatives like this, UNITAID now has more than 1.2 billion dollars. These are new sources of financing and, thanks to this money, UNITAID is financing projects by major world partners, such as the Global Fund to fight AIDS, Tuberculosis, and Malaria.

The second type of partnership is one that involves citizens. In addition to the Solidarity Tax, UNITAID created the first world-wide citizens' solidarity movement. Using the internet and credit cards, citizens can contribute when they buy something and make a micro-contribution of \$2. If each person buying an airplane ticket gives \$2 extra, we will change the world.

Bono and Bobby Shriver, with (RED)³, invented this kind of partnership, whose effort gave 140 million dollars to the Global Fund.

The third type of partnership involves pharmaceutical companies. Their innovative, sustainable, long-term and predictable financing is needed. Pharmaceutical companies, e.g. can reduce the cost of the medicines when they receive a certain amount of money for 10 years. This way we have been able to reduce the prices for AIDS medication by more than 50%. We are also working on a type of patent pool, putting patents for AIDS, Tuberculosis, and Malaria drugs together, only for poor countries. But this kind of partnership with pharmaceutical companies cannot last long if they continue to focus on rich countries.

The fourth type of partnership is with people who invest their money in investment funds. These investors should support funds that show a certain amount of social responsibility. The French Development Agency and the Global Fund are already turning toward these

new sources of funding and trying to partner with people who have money. We have already come up with 3 million dollars, and, one day, we will be able to convince also the sovereign funds to engage in this effort. This is a new architecture for aid.

The United Nations Secretary-General has created a group that is known as “I-8”, which uses innovative financing mechanisms. This group is at the service of governance and public associations and it shows the world what innovative financing can give: a new option between ODA and private humanitarian aid.

Lessons from the AIDS Movement for Current and Future Partnerships⁴

By Mr. Michel Kazatchkine
Executive Director
The Global Fund to Fight Aids, Tuberculosis and Malaria

Partnerships in global health are something relatively new. Partnerships, such as the global health partnerships for financing the fight against AIDS, TB, malaria, and fistula – have come into being only in the last ten years. They really represent a whole new way of thinking about public health. Until the 1980s and 1990s, public health was an undertaking for the collective good but it was seldom a collective effort.

Two factors have changed this thinking:

First, the globalization and the rise of truly global epidemics. The three major killing diseases of the developing world – AIDS, TB and malaria – cannot be addressed by anyone acting alone but require a global response;

Second, governments cannot fight epidemics alone.

Access to AIDS treatment and care has only been achieved through an unprecedented, multisectoral mobilization of political leaders, governments, international organizations, academia, health practitioners, advocates, community-based organizations, faith-based groups, the private sector and affected communities and people living with the disease themselves.

It is the AIDS movement that has changed the paradigm of public health from something that governments “protect”, such as through quarantine measures, to something that requires the engagement and cooperation of all sectors of society, such as HIV prevention.

It is the AIDS movement that has shown that responses to virtually any major health challenge are most effective and durable, if they are based on collaboration rather than coercion.

It is the AIDS movement that has contributed strongly to the idea emerging only in this century that health products – such as antiretroviral treatment – are not ordinary commodities but global public goods.

The response to AIDS has certainly shaped the way that the Global Fund is structured and operates. Its Board includes both donor and implementing countries, the private sector, philanthropic foundations, NGOs from the north and south, and people living with the diseases: a governance model that is unique in development financing.

Country coordinating mechanisms that develop proposal for Global Fund financing reflect a similar partnership approach. It is a model that recognizes that, while governments may often lead, other organizations – such as businesses and community

organizations – have much to contribute: as advocates, in planning, resource mobilization and implementation. It is a model based on the belief that everyone's capacity must be harnessed, if we are to tackle the major diseases effectively, addressing not only their clinical and medical impact but also their social and economic implications as well.

In concluding: partnerships in health are rather a new idea, based on the realization that the fight against diseases requires new relationships, based on shared responsibility and accountability.

But, partnerships are not without risk. For example, the founders of the Global Fund – which does not have any country offices – relied heavily on the assumption that partners in countries would play their part to support implementation of resources. Partnerships are not just about clear divisions of labour or memoranda of understanding between parties. They are about everybody being prepared to surrender some of their power, share information and knowledge, set aside differences and work towards a common goal.

Partnerships are not always easy. They require work, time, attention and open communication. They involve finding consensus among different points of view. Sometimes, they are frustrating. But a real commitment to partnership must be based on the conviction that such investments in time and effort are necessary and worthwhile for health interventions to be effective and sustainable,

There are many partnerships yet to be tapped if it is possible to maintain a dynamic and innovative movement in global health and to weather the effects of the financial crisis. New opportunities for collaboration should be used. Innovative financing provides one such opportunity but there are many others.

The Millennium Development Goals continue to provide an excellent framework for partnership, in health, and between the health and the broader development field. The MDGs remind us powerfully of our common goals. With only six years to go to the 2015 deadline for the MDGs, and in the constrained economic environment in which we find ourselves, it has never been more important than it is today for us to make partnerships in global health work.

The Global Movement of the Roll Back Malaria Partnership⁵

By Ms. Awa Marie Coll-Seck
Executive Director
Roll Back Malaria Partnership

Basic health for the world's poor is essential to global economic prosperity. Yet, the poor continue to fall sick and die from diseases that are preventable and treatable with existing public health interventions.

Malaria is an example. 300 million people contract the disease every year, even if effective prevention exists. One million die from malaria, even if treatment exists. Almost half of the world's population continues to live in places where malaria burdens economies, health systems and communities. No government or institution operating alone can achieve the malaria-related MDG.

This is where partnership comes into play. In 1998, WHO, UNICEF, UNDP and the World Bank founded the Roll Back Malaria (RBM) Partnership to provide a coordinated global approach to fighting the disease. Over the past decade, this partnership has evolved into a global movement, aligning hundreds of partners from malaria-endemic countries, multilateral development organizations, the private sector, NGOs, foundations, and research and academia. Today, the RBM Board also includes the Global Fund, UNITAID and the United Nations Special Envoy for Malaria.

Coordination and harmonization are important elements. The RBM Partnership has agreed on a single roadmap for global malaria control and elimination around which all partners are aligning their work.

Financing is crucial. RBM has directly helped countries to leverage unprecedented international funding to fight malaria. With coordinated technical assistance brokered by RBM, the success rate of Global Fund grant applications for malaria has increased from less than 30 per cent to more than 70 per cent in the past three years. Other RBM partners - in particular, The World Bank and the United States President's Malaria Initiative - are making major contributions.

Integration is another important factor. The malaria community has joined with others to develop integrated models for delivery of health services. When free mosquito bednets were distributed during immunization campaigns against polio and measles, more mothers were willing to walk long distances to have their children vaccinated and obtain protection against malaria at the same time.

Affordability is key. RBM, in partnership with the Global Fund, has taken forward an idea that first came from a group led by a Nobel Prize winning economist. They wanted to make effective malaria medicines more affordable. The Affordable Medicines Facility for malaria is an innovative financing mechanism to increase access to the effective ACT medicine and to force out cheaper but ineffective old drugs and monotherapies that fuel drug resistance. This programme is starting now with an initial roll-out in 11 countries.

Technology transfer is another priority. RBM supported a joint venture enabling technology transfer from Japan to Tanzania for the manufacture of state-of-the-art long-lasting insecticide-treated bed nets. Today, more than 20 million bed nets are manufactured annually in Arusha in an enterprise that has created 5000 jobs and boosted local skills.

Partnerships are able to deliver large-scale interventions: distribution of mosquito nets, insecticide spraying inside houses and effective medicines have helped decrease malaria rates by more than 60 per cent in countries such as Eritrea, Ethiopia, Rwanda, Swaziland, and Zambia, as well as the island of Zanzibar. All these examples show how a partnership for a specific disease delivers broad health and development gains and relieves overstressed health systems.

Of course, challenges remain to achieve the RBM 2010 targets and fulfill the United Nations Secretary-General's call for universal coverage with malaria interventions. But, the most daunting challenge is to sustain focus and financing for malaria and other major diseases, to help save lives in every endemic country and community and reach the Millennium Development Goals.

Progress in the Fight against Tuberculosis through the Stop TB Partnership⁶

By Dr. Marcos Espinal
Executive Secretary
The Stop TB Partnership

In the early 1990s, the Philippines was struggling to cope with tuberculosis. Most patients avoided the free-of-charge public health system and went to private doctors. There was a mix of different strategies that seemed to be heading for trouble. People realized they should work together, not in isolation. The Government actively sought to form a partnership with a variety of groups - private doctors, pharmaceutical companies, NGOs, communities, and the patients themselves. Thus, the Philippine Coalition against Tuberculosis, known as PhilCAT, was founded in 1994.

The Stop TB Partnership has a set of targets in the Global Plan to Stop TB - our roadmap for reaching the MDG-related to tuberculosis and halving prevalence and deaths compared to 1990 levels by 2015. One of the main targets is that at least 70 per cent of infectious cases should be recorded; and that 85 per cent should be cured. The Philippines has exceeded those targets since 2004, and they did it through a community-based partnership.

More than the success of the Philippines, this also illustrates why the world needs a global partnership against tuberculosis. The Stop TB Partnership, whose secretariat is housed and administered by WHO, is a “Bottom-Up” movement that brings together all stakeholders. Our job is to catalyze partnerships at the country level and many countries have followed the Philippines in forming a national Stop TB Partnership, such as Afghanistan, Brazil, Swaziland and Uganda. The Partnership aims to strengthen health systems by helping mainstream and integrate TB control and planning within national health plans and primary health care systems.

The Stop TB Partnership is a coordinating body, not a financial entity. Yet, we have concrete projects that help countries. The First WHO ad hoc Committee on the Tuberculosis Epidemic held in London in March 1998 stated that the main bottleneck to fighting TB was a shortage of drugs. It was to address this need that the Stop TB Partnership's Global Drug Facility, or GDF, was created in 2001. Since then, it has delivered more than 14 million treatments around the world, many of them as grants. GDF's work is today fully harmonized with that of the Global Fund. For instance, of the 89 countries procuring drugs from GDF in 2008, 38 per cent were using Global Fund monies. Likewise, the Green Light Committee helps countries access concessionally priced high-quality, life-saving medicines to treat people with multi drug-resistant tuberculosis.

The Stop TB Partnership has had considerable success in putting tuberculosis higher on the political agenda of world leaders, in particular, because of the engagement of the

former President Jorge Sampaio, the United Nations Secretary-General's Special Envoy to Stop TB. He has been a tireless advocate on raising political commitment to fighting TB. For many years, tuberculosis was an orphan of the research community. Most tools that are currently used are old. Our partners are working hard to fill this gap. A new technology to diagnose drug-resistant tuberculosis in just two days instead of the traditional two months is being introduced by countries with the help of Stop TB partners, including WHO, UNITAID and the Foundation for Innovative New Diagnostics. A number of novel drug and vaccine candidates are currently in clinical trials.

Barriers to conquer tuberculosis relate both to weaknesses in health systems and problems that go beyond the health sector. To fight tuberculosis effectively, bold new leadership and broad legislation on matters, such as social health protection, quality assurance for all drugs, and human resources for health are needed. There is some movement in that direction. Participants in a ministerial meeting of the 27 high-burden countries for multidrug resistant tuberculosis, held in Beijing in April 2009, called for the implementation of strategic new policies aimed at achieving equitable access to care. The urgency of identifying and addressing the underlying social determinants of tuberculosis also were addressed.

Similarly, the devastation that tuberculosis and HIV/AIDS are causing together, especially in Africa, is a tremendous challenge to the international community. In this regard, the Stop TB Partnership is working closely with UNAIDS through joint advocacy and social mobilization efforts. Tuberculosis is a disease of poverty - and an important contributor to poverty. Tuberculosis mainly affects women and men during their prime working and child rearing years, between the ages of 15 and 44. When any breadwinner becomes sick with tuberculosis, the family may well face financial catastrophe. When a woman becomes sick with tuberculosis, her illness can have a devastating impact on her children and any elderly family members she cares for. Children who become ill with tuberculosis miss educational opportunities.

It is well known that the changes that are needed to mitigate the poverty-tuberculosis link go beyond health. But we also know that fighting tuberculosis through the health sector is highly cost effective. A World Bank research report recently published found that countries with the world's highest number of tuberculosis cases could earn significantly more than they spend on diagnosis and treatment, if they fully implemented the Global Plan to Stop TB. Highly-affected African countries, for example, could get up to a nine fold return on their investments in TB control.

MDG 6 has been achieved globally with respect to tuberculosis. This is because the incidence of tuberculosis - the proportion of the world's population that becomes ill with the disease each year - has been declining very gradually since 2004. This is, indeed, ironic. We have met the goal, yet there are still nine million people becoming ill with tuberculosis each year, and nearly 5000 people die from it every day. It is because TB control and research and development are under-funded and, despite all our efforts, political commitment is still insufficient.

There are a number of new diagnostic tools, drugs and vaccines in the pipeline. By 2015, we expect to have a vaccine that could protect two-thirds of all people against

tuberculosis. Available projections show this vaccine could reduce TB cases and deaths drastically between 2015 and 2050 - by 80 per cent in Southeast Asia, for example. The international community should seriously consider an advance market commitment to this vaccine.

Strengthen Partnerships in Support of the Campaign to End Fistula⁷

By Ms. Natalie Imbruglia
Spokesperson for the Campaign to End Fistula
United Nations Population Fund

Every minute a woman dies in what should be one of the most joyous times of her life: She dies in pregnancy or childbirth. For every woman who dies, 20-30 women suffer a serious birth injury. One of the more devastating of these injuries is obstetric fistula. It does not have to be that way. It is well known what it takes to save the lives of these women. It is well known how to prevent and treat fistula.

I first learned about fistula and the Campaign in 2005 from my friend Richard Branson, who was so moved by the topic that he asked me to become an ambassador for his non-profit foundation, Virgin Unite, to help raise funds and awareness for the UNFPA's Campaign to End Fistula. Since then, I have had the honour of visiting fistula hospitals in Ethiopia and Nigeria numerous times. In Ethiopia, I met a very shy 17 year old girl named Tegest, who shared her story with me. She was in labour for five full days before her baby died. As if that were not enough, Tegest developed a fistula, and her husband left her because of the smell of urine and feces.

During my time as a spokesperson, I have met many women like Tegest - young and old - whose bodies have been torn apart from difficult pregnancies. I have heard the stories of births undertaken on a mud floor without any skilled assistance, of days of labour, and of health systems that are ill equipped to properly care for women, before, during and after pregnancy and labour. But I have also met women who have reclaimed their lives after successful fistula operations. Fistula is not something that people like to talk about. It is a very shameful thing for the girls and women affected, and, often, policy makers are not comfortable with it either. But the topic needs a voice, and I am happy to lend my voice and give my time to end fistula.

I have some powerful partners in Virgin Unite and the United Nations Population Fund (UNFPA). Thanks to the money we have raised, so far, our joint programme has contributed to the health, economic and social upliftment of thousands of women in northern Nigeria. But it goes beyond that. The partnership between Virgin Unite, UNFPA and the Campaign to End Fistula is helping ensure that fistula is no longer something that is hidden, forgotten and unspoken. And it is getting on the agenda. Otherwise, I would not be standing here today.

The good news is that it is possible to end fistula and to relieve millions of women's suffering. Like maternal mortality, fistula is almost entirely preventable if women have access to reproductive health care, family planning, skilled birth attendants and emergency obstetric care if things go wrong. For the millions of women who are already living with fistula, a simple surgery can normally treat the injury for only around € 235.

Sadly, most women with the condition either do not know that treatment is available, or they cannot afford it.

This slot in the programme is called ‘Partnership in Health’ and I would like to ask each and every one of you here today to become a partner: When you return home, I hope that you will work to ensure that fistula and maternal health are properly addressed in your countries and integrated into your health care systems. I hope you that will join me in making fistula a thing of the past.

Notes

- 1 From the 2009 ECOSOC high-level segment, 6 July 2009.
- 2 Ibid.
- 3 For more information, please visit: <http://www.bobbyshriver.com/red.php>
- 4 From the 2009 ECOSOC high-level segment, 6 July 2009.
- 5 Ibid.
- 6 Ibid.
- 7 Ibid.

Chapter 5

SOCIAL TRENDS AND EMERGING CHALLENGES AND THEIR IMPACT ON PUBLIC HEALTH: RENEWING OUR COMMITMENT TO THE VULNERABLE IN CRISIS

Overview

The current financial and economic crisis is creating poverty traps for millions of poor people. Contractions in economic activity will likely contribute to the unemployment of between 24 and 52 million people globally. Although the economic crisis will significantly impact the entire population, specific vulnerable groups are particularly at risk. These issues, in relation to public health, were addressed at the 2009 ECOSOC high-level segment thematic debate on “Social trends and emerging challenges and their impact on public health: Renewing our commitment to the vulnerable in a time of crisis,” held on 9 July 2009, at the Palais des Nations in Geneva.

Mr. Richard Newfarmer, Special Representative of the World Bank to the United Nations and the World Trade Organization, addressed aspects of the financial crisis, the current recession, and the international development agenda. Based on knowledge of past economic downturn, the current global recession could leave 200 million people trapped in poverty; unemployment will increase, infant and child mortalities will rise and health services will be cutback. Low-income countries are at the highest risk, and will continue to face challenges with the provision of support to workers and the poor. Additionally, countries vulnerable to climate change are the same countries especially vulnerable to the recession and being inattentive to the long-term development agenda, specifically in regards to climate change, can pose great risks. Together, the financial crisis and climate change could cause major declines in food production and pressures on migration. However, this can be met with a multilateral response including the completion of pledges for development assistance, resisting trade protection (including restoring a commitment to the Doha Development agenda) and improving the regulation of financial markets. In conclusion, he stated that the World Bank Group was working to increase financial flows to middle- and low-income countries as a step toward improving financial markets.

Ms. Carissa Etienne, Assistant-Director-General of Health Systems and Services at the World Health Organization, examined in detail the financial and economic crises on public health. She stated that the MDGs will not be met in many communities, and that the financial crisis further threatens the achievement of these goals. The economic crisis could increase the gap between the rich and the poor, as well as increase maternal mortality. To prevent this gap, risks should be anticipated and early warning mechanisms put in place. More specifically, there is a need to look closely at nutrition levels (women and children tend to be impacted first), to address the increased demands on public health services, and to explore the impact of the economic crisis on social protection. It would be necessary to maintain the levels of financing for international health development by establishing and maintaining new mechanisms and building them into national plans and

budgets, monitoring the impact of the crisis country-by-country and anticipating the end of the financial crisis are regarded as important factors in overcoming the crisis. By anticipating that the crisis will end, basic reforms must be ensured that the health sector will be in a better position to channel future growth with greater equity. This means that primary healthcare approaches should be adopted, as Member States have agreed upon. She concluded by stating that improving health outcomes is not only the responsibility of the health system, but rather the collective responsibility of all people.

Mr. Assane Diop, Executive Director of Social Protection and Employment at the ILO, reiterated the impossibility of achieving the MDGs by 2015 and advocated for a recommitment to assisting the poor. He referred to the reality of the challenges faced by the rural poor, which include lack of access to social security and health facilities. Mr. Assane pointed to the exodus of health professionals from the poor countries into the rich countries. About 70 per cent of the remittances of these workers, however, are channeled to health care in their home countries. The rural poor in Sub-Saharan Africa spend, on average, \$30 per year on health care, coming out of their own pockets because they have no access to social security. This figure is 100 times less than that of their counterparts in rich countries. The human tragedy behind the quantified poverty (those living on less than \$2 per day) is not revealed but is very real. It would be important to look at the situation from the eyes of those who need the help and assisting them in their own approaches on a voluntary basis.

Dr. Alberto Palloni, Professor of Demography and International Studies at Northwestern University, explained how the economic crisis can aggravate the situation of the elderly and children in developing countries. The ageing process in developing countries is very different from high-income countries. The unprecedented increase of the elderly in developing countries is not only a result of a decline in previous mortality and decreased fertility rates. The proportion of the elderly compared to the society is also influenced by current fertility rates, and by past decreases in older-age mortality. The effects of such demographic changes include dangers of increased risks to diabetes, cardiovascular diseases, disability and lower levels of healthy life expectancy. Additionally, the increased ageing process is taking place in a fragile economic environment also characterized by the erosion of the traditional family, the diminished role of the public sector, increasing poverty and inequality. Mortality decline in early childhood is a contributing factor to the rate of growth of the elderly. The importance of early health is not only to decrease infant mortality but is in effect a contribution to future human capital. This also has an impact on economic growth. The determinants of adult wages, such as parental background also known as “wallets”, are educational attainment, cognitive and non-cognitive traits and early health. The current dilemma faced by the family and society at large are how to balance old age-related expenditures versus future investment in child health, which translates to human capital and future economic growth.

Ms. Marcia Metcalfe, Global Manager for Microfinance and Health Protection, Freedom from Hunger, stated that her organization has been working with microfinance organizations to integrate health services with microfinance to improve health and financial security of the extremely poor. Though microfinance is a powerful poverty alleviation tool, more is needed to help the very poor with issues including childhood

malnutrition, maternal and child mortality, the spread of HIV/AIDS and preventable diseases. Thus microfinance providers are willing to supply access to health education and services but they have to be shown how to do this without harming the microfinance institutions' (MFIs) financial sustainability. Moreover, one of Freedom from Hunger's initiatives, the Microfinance and Health Protection Initiative (MAHP), is working with MFIs to show that when MFIs include health services, they are advancing their social goals as well as improving their financial and competitive positions. She also referred to microfinance as an opportunity for women to mobilize resources for health. These women also have substantial influence on other individuals in the same household in regard to core behaviors that affect health and social welfare.

Financial Crisis, Recession, and the Development Agenda¹

By Mr. Richard Newfarmer
Special Representative of the World Bank to the United Nations and the
World Trade Organization

Beginning in September, with the crisis in Lehman Brothers, panic swept the world's financial markets. It emanated from the United States and rippled through to Europe and soon the rest of the global economy. Beginning with the third quarter in 2008, GDP plummeted. The United States economy contracted very sharply, particularly in the fourth quarter, as did Japan and the Euro zone, and lasting well into the first and second quarters of this year.

This reflects what happened to consumption in those countries as the financial panic destroyed trillions dollars worth of pension funds and housing values. People were left with less wealth and, as a result, immediately began to reverse their patterns of consumption in the rich countries. That, of course, ramified immediately through global trade to the developing countries. The annual growth in world trade volumes crashed in 2009. This was the first contraction in global trade since 1981. The World Trade Organization issued their latest projections at -10 per cent for 2009. This has become a major channel through which recessionary forces in the North have been transmitted to developing countries in the South.

But that was not the only channel; a second channel was capital flows. As the financial crisis and panic ensued, interest rates shot up immediately, and the spread that the banks were charging both corporate and sovereign borrowers in developing countries at the end of 2008. It shot up from about 200 basis points up on average to nearly 1,200 basis points towards the end of the year. These numbers, happily, have come down somewhat since, but that spike in interest rate has been enough to basically cause financial markets to retrench deeply private capital flows to developing countries. They peaked at 1.1 trillion dollars in 2007, and have, since 2008, come down to the order of 750 billion dollars, but this year, are expected to be only about one-third of what they were from that peak in 2007. And this, of course, has severe implications on the ability of public sectors to finance their public expenditures in health, in education and in social protection.

The contraction in global trade and the contraction in global finance pushed everybody into recession, and this is the first recession that has been seen in 70 years. The annual growth rate of GDP in developing countries for the last four to five years between 2001 to 2006-2007 showed that they were doing very well, and that they were growing at 6 to 7 per cent annually. However, the crisis in the rich countries, with basically 70 per cent of global GDP that is accounted for by the United States, Europe and Japan, going into recession, has dragged down all of the world and with it, developing countries. It was forecast this year developing countries' growth rate to be in the order of collectively 1.5 per cent or 1.6 per cent, whereas the high-income countries are going to have a contraction in the order of 4.5 per cent. Though the world economy does not look like the

Great Depression, it certainly is equal to what Martin Wolf has called the ‘Great Recession’.

The effects across regions are actually quite different. If we look, for example, in East Asia, driven in part by growth rates in China, and South Asia, also driven by growth rates of India, the forecast for this year will not be too bad. Basically, there should be growth rates of 5 per cent in those two regions - four and a half to five per cent. The Middle East is in the middle. That’s the end of the good news. Growth in Sub-Saharan Africa is at one per cent, Latin America is contracting by 2.3 per cent and Europe and Central Asia contracting by 4.7 per cent; that is where the most devastating aspects will be. A one per cent growth rate in Sub-Saharan Africa, of course, means a contraction in per capita income. It also means what economists call a “growth recession”; that is, the economy may be growing but it is not growing rapidly enough to absorb the increase in the labour force. So, private consumption in Sub-Saharan Africa is expected to decline on a per capita basis, as it will certainly in Latin America, Europe and Central Asia.

So what is the outlook? Well, recovery could begin later this year or next year; in fact, the IMF has just upgraded, somewhat marginally, its forecast in a report recently released. We know that recessions do end; we know that there has been a lot of fiscal stimulus in the economy; there has been a lot of policy stimulus coming from low interest rates and monetary policy, and we are beginning to see already some of the issues that would indicate a turn-around in the global economy. What we do not know - and this is the great uncertainty - we do not know how strong that recovery will be and whether or not it will hit another bump in the road that might push these numbers back to negative territory or at least prolonged stagnation, such as what we saw in Japan in the 1990s. The good news is, to the extent there is good news out there, is that some 23 of 24 major forecasting houses around the world now predict some positive growth in 2010. In fact, we have seen some tentative signs that the recession, in fact, is beginning to ‘bottom out’ and first of all led by developing countries, particularly China. It has been seen in the latest high-frequency indicators, that they have begun to stabilize.

Developing countries are leading the recovery. In addition, when looking at the bigger picture, credit markets have stabilized; interest rates have come down - they are not exactly where they were before the crisis began - but the markets have stabilized. Equity markets have actually bounced back a little bit. We have seen markets in high-income countries come back some 6 per cent since the first of the year. Emerging markets have done somewhat better, anywhere between 20 and 30 per cent. Likewise, the United States is seeing some signs of confidence emerge, as savings rates and consumer confidence have finally begun to rebuild. It was recently seen in Europe the fact that orders of machinery coming from Germany were back up. That is an important sign because it means that there is some uptake on the investment side which had been the part of GDP aggregates that had fallen pretty substantially.

The recession appears at present to be ‘bottoming out’. Still, many countries have been adversely affected and it will take time to undo the damage. Low-income countries are at particular risk, especially those that export only a few commodities, have weak fiscal positions, have low reserves or are in fragile states. There is a map done by colleagues at the IMF, which basically shows countries that are most vulnerable from a poverty

perspective, countries with medium vulnerability and countries with low vulnerability. The whole global recession is likely to leave some 200 million people trapped in poverty, roughly 100 million because of the slow-down in growth and another 100 million because of the adverse price shocks associated with rising food prices and rising fuel prices. We also know that unemployment will likely be substantially higher in 2010, in fact, will continue well into 2010 and even into 2011. Why is that? It is because recovery in labor market tends to lag behind recovery in the output markets by some 12 to 24 months. We know that infant mortality will be adversely affected, simply because as consumption declines, people spend less on health and, of course, those in rural areas have less access to health as a consequence.

There is also another risk - the risk to the long-term agenda. There is a large possibility that if we do not maintain our focus on the crisis, what Mr. Juan Somavía has called “the crisis before the crisis”, the long-term development agenda will be adversely affected. One particular area is climate change. Many countries are being exposed to droughts, to more severe storms, to rising water scarcities, and even to rising sea levels. Many of the same countries that were affected by the recession are also affected by long-term climate change. This underscores the urgency of both getting the recovery going so that it doesn't become a lost decade and, at the same time dealing with these long-term issues. Because it is known that climate change is going to have dramatic impacts on food production, it is going to have dramatic impacts on migration and also imply significant health risks throughout those countries that are adversely affected. These, again, are the same countries adversely affected most by the current recession.

So far, one element of good news is that there has been a multilateral response. The G20 leaders have begun to coordinate actions in several areas. An accelerated restructuring of banks and regulation has begun to take place. The pledge to avoid trade protection, has indeed, had some moderate success in keeping trade barriers relatively low in a time when protectionist pressures certainly are to rise. The coordinated fiscal and monetary stimulus has been a major success from the efforts of the major countries to revive the global economy, and that is one of the reasons why we are beginning to see the recovery, however tepid signs are beginning to emerge.

Also, mobilizing more capital for developing countries through the IMF and the World Bank, and through the other multilateral development banks, has been important. The World Bank has tripled its lending to middle-income countries and increased allocations to low-income countries. But that is not enough in our view; we think things can go further. There needs to be greater multi-lateral collaboration and response particularly in three areas – the first and perhaps most important is development assistance.

This will not be easy. Fiscal stimulus programmes have generated large deficits, not only in the United States and Britain but also the rest of Europe and Japan. There will, inevitably, once recovery sets in, pressures on those fiscal budgets to retrench - to cut the fiscal deficits. One area of expenditure that is vulnerable in these discussions is development assistance and yet, now is the time when, if anything, we need more development assistance. It is needed for social safety nets, for labour intensive infrastructure, and it is needed for aid to small- and medium-size enterprises which create jobs. It is also needed for aid for trade and health and social protection. It is estimated

by the Bank that financial gaps will be anywhere between 200 to 700 billion dollars this year and next year, depending on what actually happens and how the global economy actually evolves. That financing gap is important to fill, in order to solve the problem. Yet the multilateral development banks, having responded to the crisis with increased lending, are running out of headroom to lend more and capital constraints will curtail their lending at precisely the time when they should be lending more. Moreover, the coming round of commitments to IDA-16, the no-interest window of the World Bank is coming up for replenishment. It is terribly important for low-income countries that past pledges be translated into firm financial commitments. We all have to work very hard to move very fast on the multilateral agenda.

Improving Health Outcomes in an Economic Crisis²

By Dr. Carissa Etienne
Assistant Director General for Health Systems and Services
World Health Organization (WHO)

I would like to address the priority areas for focus when facing the challenges posed by the current financial and economic crisis. The difficulty is, of course, that one does not start from a great baseline. This financial crisis is occurring on top of a food and fuel crisis and what can be characterized as a crisis in confidence regarding health.

Today, people expect to live in safe communities where their public health is protected. They expect to have access to quality health services where they are treated with dignity. And they expect the authorities and providers to guarantee that access. These expectations persist, and increase, even in a financial crisis. It is our job to ensure that expectations are met. Too often, they are not.

In recent years, we have witnessed a complex interplay of factors - environmental, social and economic, which have impacted the health of individuals and communities. We have seen the rise in chronic non-communicable diseases - not just in rich countries, but among the poor. At the same time, we have seen a continued high incidence of infectious diseases. New and emerging viruses like H1N1 affect all people, but the poor are disproportionately impacted.

There have been epidemics of dengue and dengue haemorrhagic fever and other vector-borne diseases attributed to climate change. This has resulted in MDGs which are unmet in many communities and which are now further threatened. And this has all occurred against a backdrop of inequity, an inequity that pervades within and between countries; an inequity towards which people have rightly become increasingly intolerant. The economic crisis could make these gaps even wider. In affluent countries, people are losing their jobs, their homes, and their savings. Access to healthcare may become more difficult. But in developing countries, people could literally lose their lives.

So how do we prevent this happening? How do we prepare?

We must anticipate. We must anticipate risks and institute early warning mechanisms.

As the social risks increase, we must anticipate worsening of the pre-existing situation and anticipate new challenges. For example, we need to be alert to an increase in mental illness, and a greater dependence on tobacco, alcohol, and other harmful substances. We also have to look at nutrition levels. We know from the past that women and young children are among the first to be affected when resources are short. Not just in low-income countries, but in richer ones too, where processed foods, high in fats and sugar and low in essential nutrients, have become the cheapest way to fill a hungry stomach.

We must anticipate increased demands on the public health services. When money is short, people tend to forego private health care and make more use of publicly financed

services. This is fine, so long as public health systems are strong. But in many countries, systems are already vastly overstretched and under funded.

A further problem is that economic crises increase pressure on social protection. Higher levels of unemployment boost demand for welfare at the very moment that payments fall. At the same time, savings and pension funds run out, and there is less money available to spend on health. Another important point is that prevention often gets left behind. We have often seen that when funds are low, investment in prevention falls. This is particularly disturbing at a time when ageing and a rise in chronic diseases are global trends.

The next, and linked, concern is maintaining levels of financing for international health development. Since the start of this century, external assistance for health has more than doubled. Nevertheless, around half of the world's countries still lack the capacity to finance even the most rudimentary "survival kit" of basic health services. At the start of this year, well over 3 million people in low- and middle-income countries were receiving life-prolonging antiretroviral therapy for HIV. This has largely been made possible by investments from international organizations. But we are already hearing anecdotes that in some countries, voluntary testing sites are at risk of closure and treatment programmes are threatened. Interruptions in the supply of drugs, especially for diseases like HIV, TB, malaria, and chronic non communicable diseases contribute to preventable deaths in high numbers. They can also accelerate the development of drug resistance.

So what does all this mean in concrete terms?

It means protecting and increasing spending for health and social protection. This means establishing and maintaining new mechanisms - and building them into national plans and budgets from the start.

It means monitoring the impact of the crisis, country by country.

We must anticipate that the crisis will end. We must, therefore, ensure the basic reforms now which will better position the health sector to channel future growth into greater equity.

It means adopting primary health care approaches. In May this year, Member States agreed on a resolution on primary health care, which embodies the values of equity, solidarity and social justice and stresses four basic policy directions: universal and equitable coverage; comprehensive, people-centered primary care; active participation of all people, individuals and communities, in developing and implementing policies and programmes, the inclusion of health in all policies and lastly inclusive governance and leadership.

Improving health outcomes is not just the purview of the health sector - nor just the responsibility of governments- especially not in times of economic crisis.

It is our collective responsibility.

Dedicating Health Resources to those who need it³

By Mr. Assane Diop
Executive Director, Social Protection Sector
International Labour Organization (ILO)

Already before the fuel crisis, the food crisis, global warming and the financial and economic crisis, nearly one billion people were living on the edge of survival. They do not have decent work: they are unemployed or work in poverty, especially in rural areas and informal economy. With no thread of security, they are facing an increase in hunger; floods and droughts; and health risks.

They have less than ever before the means to finance essential health care of their family members, child beds or taking care of their new born.

In countries with a high poverty rate, where a large percentage of the active population works in the informal economy, ILO estimates that nearly 75 per cent of the population does not have access to health services, mainly due to the fact that healthcare and medicine are inaccessible. In Burkina Faso, the figure is 80 per cent.

In Sub-Saharan Africa, on the average, the total health costs have risen to US\$30.00 per person annually, one hundred times less than in the OECD countries. More than half of this amount is spent by private households for themselves. The impoverishment of millions of people there is imputable. There is neither sharing of the burden nor solidarity in the financing of the already limited healthcare and, too often, spent inefficiently.

It is, therefore, obligatory to implement or to expand the social protection of health. Taking the kinds of national health services, social medical insurance, communal health plan systems and others, social protection of health makes the use of meager resources more efficient through the pooling of risks and of pre-payment.

- It can increase the equity, reduce poverty and improve the health of the population.
- It can reduce the mistakes in the access to quality health services, improve the lowering of the rate of maternal mortality and the survival of the new-born, reduce the transmission of HIV from the mother to the baby and prevent and treat malaria.
- It targets the limited resources on those who need it.
- While promoting development and economic growth, trickling in a workforce in good health, it in itself addresses the crisis and, at the same time, improves the situation of the most vulnerable.

Poor communities, governments, workers and the employers of the whole world have established systems either with health insurance or financed by taxes. These show how solidarity can accelerate progress in the protection of health. They play a key role in the protection of the underprivileged, ensuring as well the quality and equity in care. Over

the past years, South Korea, Thailand and Ghana, have all brought about important progress in spite of the initial constraints, such as weakness of the gross domestic product (GDP) per capita or the importance of the informal economy.

As the convention no. 102 on social security indicates, our work is firmly established in the rights of social security and health, which are at the heart of our agenda on decent work. The agenda is one of the cornerstones of an equitable globalization.

You may know that our innovative programme (strategies and techniques against social exclusion and poverty) established points of reference with regard to the promotion and development of community-based systems, such as micro health insurance systems. It connects the poor, the experts and the resources and gives them the means to fight together against social exclusion and poverty.

Now, in a period of economic decline, ILO calls on all inclusive responses rather than excluding from the public budgets the needs of the poor on health matters. We urge governments to use the full potential for social protection of health, ensuring also that the benefits be affordable, as well as adequate.

Governments ought to take into account the fact that the global deficit with access to health services cannot be treated only through the health system. There is, moreover, a need for a wider political approach, based on redistribution and protection, in order to address the underlying inequalities in the heart of societies and at the global level. An essential contribution to such policies is the new initiative for a social protection floor, being a part of a joined Initiatives (Joint Crisis Initiatives) recently launched by the High-level Committee on Programmes of the United Nations System Chief Executives Board (CEB).

The social protection floor will be composed of two principal elements that contribute to bringing about human rights:

- Essential services: geographical and financial access to water and to sanitation, to adequate food, to health care, including maternal and child health, and to education.
- Social transfers: an essential part of these transfers, in cash or in kind, given to poor and vulnerable people, in order to provide a minimum of security of income and access to essential health care.

Access to health care, especially for the most vulnerable, ought to be a priority in national politics. Access may improve through pluralistic systems of social and health protection, providing essential benefits that respond to the needs of women, men, children and the elderly.

We underscore equally the need to contain the exodus of qualified workers, as a result of bad work conditions in numerous countries with poor income.

The migrant workers compose a particularly vulnerable population in terms of health and job security. Even there, where systems of social security or health insurance exist, migrant workers and their families are often excluded and, therefore, do not enjoy the fundamental right to health.

Today, 50 per cent of international migrants are women, more and more workers rather than dependent persons. That 'feminization' of migration requires approaches that are sensitive to gender equality.

The financial and economic crisis has led to job loss, particularly among migrant workers. By losing their job, these workers may also lose their right to remain in the host country and, consequently, their health insurance coverage.

However, the migrant workers in a regular job pay their contribution to the social security and health insurance systems in their host countries. The resources of these systems will be thus hit by job reduction affecting the migrants. In parallel, the current crisis has a strong impact on the remittances, which bring a major contribution to the health costs of families and of communities of the countries of origin.

Furthermore, there is a global shortage of health personnel, estimated at 4.2 million workers in 57 countries, of which 36 are in sub-Saharan Africa. Thus, around 23 per cent of doctors trained in Africa work in the OECD countries, while 20,000 health workers left Africa for Europe and the United States. That deprives the populations of the countries of origin of the access to quality health services, putting at risk the viability of the health systems – especially in the rural areas – and causing a loss of public funds invested in training. The response of the countries of origin must include a sustainable planning of the health workforce, as well as strategies for retention – but also bilateral and multilateral agreements based on international instruments for socially responsible recruitment. Convention no. 149 of 1977 on nurses provides advice on the subject.

Poverty is a crisis by itself. For those affected, less than one dollar a day is just a figure. But this figure illustrates a human tragedy, which manifests itself by a patient who dies from a lack of care, a malnourished pregnant woman who risks dying or who dies of hunger with her baby.

Let us think about those who do 15 to 20 km on foot, on the back of a donkey – or by cart for the luckiest – in order to reach a health post often without medicine. To the AIDS patients who do not even know if there are the anti-retrovirals. Malaria, diarrheal disease, cholera... these diseases of the poor, which decimate pregnant women, the newborn and children require us to recognize that we will not reach the Millennium Development Goals in 2015. Worse: in some cases, we risk stating the setbacks in proportion to the recorded progress in the past – that because of the crisis which has widened and deepened poverty.

If we want to bring about a strong response now, and the scope of the deficit, we must:

- Evaluate the path taken with international financial plans;
- Evaluate the impact at the national level;
- Re-evaluate the deficits;
- Stay engaged – the United Nations system, the G-20 and the other stakeholders in the realm of health and the struggle against poverty – with new strategies, with new indicators for human development, in order to ensure a more dignified life, more just and more decent for all.

The result is within our reach. Together we can do it.

The Health of Children and the Health of the Elderly: Implications for Economic Growth⁴

By Dr. Alberto Palloni
Professor of Demography and International Studies
Northwestern University

This presentation does not highlight directly the effects of the crisis per se, but on underlying trends that can only be aggravated by the crisis. I focus on two of the vulnerable groups – they are identified in the background document, namely, older people and children. Finally, the scope is limited to low-income countries only.

With respect to elderly people, I emphasize three issues. First, ageing in developing countries - the transition towards an older population is proceeding following a peculiar trajectory. Ageing is occurring very rapidly and it has a remarkable origin. Unlike what many people think, ageing in developing countries is produced not only by decreased fertility, but also by past mortality decline. Second, the potential erosion of the traditional family may have undesirable implications for elderly support. Third, ageing is taking place within fragile institutional contexts. These three dimensions will lead to heightened demand for elderly care.

The ageing process in developing countries is very, very different from what has happened in high-income countries. The first part that is different is the demographic part. Many think of ageing as simply the proportion of people who are over 60-65 and that is the way we measure them. If you accept that, you should know that those proportions are determined by current fertility, which is going down, and by past decreases in older-age mortality. But there is a second indicator of ageing which is more important and that is the rate of growth of the population over 60 or 65. This is determined by past fertility, by past mortality decline in early childhood (a decline that started nearly 30 to 40 years ago), and by past decreases in older-age mortality. Rapid ageing occurs because the rate of increase of the elderly population is much higher than the rate of increase of the rest of the population. As an example, I will show the magnitude of the rate of increase of the population aged 60 and above. These are the rates of growth of the population over 60 in several countries in Latin America in the decades of the 1950s, 1960s, 1980s, 1990s, and projected for 2015 and 2025. If one draws a line across from the earliest to the latest decade, one would project that by 2035, the rate of increase of the population 60 and over is going to be .04. That leads to what I call the rule of 17: the rate of increase of .04 of the older population means that population will double its size every 17 years.

Ageing is occurring in a very compressed period of time and, just to show you how compressed it is, I will compare how long it takes for the proportion of people over 65 to go from 7 to 14 per cent in several countries. In France, it took 115 years; in China, it will take 27 years; in Brazil 21 years, and in Thailand 22 years.⁵ That is the rule of 1/4: it takes 1/4 of a time that it took for Europe to get to the same point in terms of ageing.

Another important characteristic to keep in mind about the ageing of these countries is its origin. The rate of growth as high as .04 per year of the population 60 and above is attained because there was a growth in past birth cohorts – those born anywhere between 60 and 90 years ago—but, most importantly, because those who will turn 60 and over after 2000 were born in the period 1940 and beyond, which was characterized by massive mortality decline. This brings me to the rule of two-thirds.

Two-thirds of the rate of increase of the population 60 and over in developing countries will be due to the fact that in 1930 through 1970, there was a substantial decline in early childhood mortality. Individuals who would have died are now becoming parts of elderly cohorts, and this has one important implication. Those individuals are marked and scarred by the experience of infectious diseases. They were saved not because they were better nourished, not because they enjoyed better standards of living, but because of the deployment of medical technology. The consequence of this is that cohorts who will populate the oldest age groups between now and 2030 have an average frailty which is higher than what it should have been had these countries followed on the heels of developed countries. Thus, older people in developing countries will probably have a higher prevalence of diabetes and cardiovascular disease. In Mexico, for example, the odds are increased between 20 and 40 per cent. There are going to be higher levels of disability among the elderly. The odds are increased between 30 and 50 per cent in Mexico and this means that elderly people will have lower levels of healthy life expectancy, that is lower average number of years of life lived without disability or disease. In Mexico, the decreases in healthy life expectancy are estimated to be between 11 and 14 years.

The traditional family in developing countries and particularly in Latin America is being eroded. There has been a sharp fertility decline induced by a shift of values and part of that has to do with the change in the ideology about the role of the family is. There is something else happening, too: because of the reduction of fertility in these countries, there has been a sharp reduction in the supply of kin. The supply of kin is a key element that controls the support of the elderly. The ratio of people anywhere between 15 and 50 to elderly people has been declining steadily in Latin America from values of around five to around two.

There is another change that goes together with changes in the demographics of the family and that is the ideological context. There is a change of values regarding children; the old age security motive is waning, but the most important part has been the weakening of the intergenerational contract. Children are no longer motivated to support older people.

Finally, ageing is occurring within a fragile institutional context. We all know about lack-luster performance of aggregate economic growth. The crisis has made that worse. There has been a diminished role of the public sector and, in many countries, this is completely inexistent. Poverty is rampant and inequality is massive. This is not an auspicious socioeconomic context for rapid and compressed ageing to occur.

With respect to children, my presentation deals with the influence of early child conditions on future economic growth. I emphasize two themes. First of all, early childhood has a strong impact on the acquisition of individual traits, cognitive and non-

cognitive and, through them, on social and economic achievement. These outcomes eventually translate, several years down the line, into human capital with implications for economic growth

Early childhood health is very important not just for older health, but also for the acquisition of traits that are important for human capital. The most important determinants of wages everywhere are parental background, what I call wallets, educational attainment and cognitive and non-cognitive traits, as well as early health. If one tries to explain differentials and variability and wages among adult people, you will find that 51 per cent of the difference is due to cognition, 9 per cent is due to educational attainment, 31 per cent is due to what your father gave you, and 9-10 per cent is due to early health. So, the contribution of early health for human capital is very important and, in periods of crisis, the most important thing that we have to keep in mind is that investment in children's health is not going to just pay in lower infant mortality, but is going to pay in an accumulation of human capital 20 years from now.

So, the dilemma we face now is a dilemma that occurs within families and society, at large. We are torn by having to invest on old-age expenditures to produce healthy ageing and pressure to invest in children's health to boost the potential to create human capital and future economic growth.

Microfinance as a Platform for Strengthening the Commitment to Health Improvement and Protection of the Poor⁶

By Ms. Marcia Metcalfe
Global Manager for Microfinance and Health Protection
Freedom from Hunger

Every day, in all parts of the world, there are thousands of microfinance workers traveling out to poor communities to meet with groups of poor people, mostly women, traveling on foot, bicycle, motorcycle, and public transportation, even to communities effectively beyond the reach of all other service providers. This is a vast private-sector infrastructure of service delivery that is mostly self-financed by interest on loans. It offers an opportunity and a challenge to use this infrastructure to extend the outreach of public health education, products and services. Given we have to use already established resources more efficiently and effectively, Freedom from Hunger has been working with microfinance organizations for the past 20 years to integrate health education and services with microfinance to protect and improve health and financial security of the very poor. Here is why.

Reach of microfinance

Over 3500 microfinance institutions (MFIs) around the world are providing credit and other financial services to more than 155 million people,⁷ helping them to start and grow businesses, build productive assets, and better cope with financial shocks—at interest rates typically well below those charged by traditional moneylenders. Moreover, MFIs strive to serve those most in need. Estimates of the portion of MFI clients that are very poor, as defined by the MDGs, range from 22 to 69 per cent⁸. Even the most conservative estimates indicate that MFIs reach at least 34 million poor households, representing 170 million of the very poor, many of whom live in remote, rural areas in the world beyond the reach of public health agencies, both private and government.

Microfinance as a platform for health

Most microfinance providers recognize that, while access to financial services is one essential and powerful poverty alleviation strategy, it is insufficient on its own to address the needs of the very poor to combat serious issues, such as childhood malnutrition, maternal and child mortality, the spread of HIV/AIDS, and suffering due to other preventable illness, such as diarrhea and malaria. In Benin and Burkina Faso, poor MFI clients reported spending up to 30 per cent of their income to combat malaria alone, and many others throughout India, the Philippines, and Bolivia described how just one serious illness could wipe out a poor family's hard-earned gains, pushing them back into the abyss of extreme poverty and food insecurity⁹. These health challenges force microfinance providers to recognize that their clients need both microfinance and health

services, if only to enable their clients to be good clients, depositing savings and taking loans and repaying them on time. They are willing to try providing access to health education, products and services, but they need to be shown how to do this without damaging the MFI's financial sustainability.

At Freedom from Hunger, we are currently working with 25 MFIs and many other organizations¹⁰ to reach 1.4 million women (or 8 million people altogether when we include the households of these women) to help them add non-financial services, such as education and health protection to leverage the power of microfinance to reduce poverty, empower women, and to improve the health of the chronically hungry poor. Our experiences, along with those of others such as BRAC, Grameen Bank, Pro Mujer, Jamii Bora, and many others are demonstrating the power and potential of microfinance for poverty alleviation, and protection of the most vulnerable from both financial and health related shocks.

Several key attributes of microcredit and savings programmes combine to make them an important component of a comprehensive global strategy to maintain the commitment to the most vulnerable in the current crisis.

Microfinance provides established access and distribution channels

Microfinance services are often provided in groups, bringing women together on a regular basis over months and years to repay loans and deposit savings. Every day, thousands of microfinance staff head out into poor communities, even to remote areas via motorcycle, bicycle, and foot to facilitate these credit and savings groups, providing an established and trusted intermediary with the outside world, a dependable delivery channel for health education, health financing tools (such as health loans, health savings, and health insurance products), and to provide linkages to other essential health products and services, such as insecticide treated bed nets, screening exams, and more.

Sustainability

MFIs achieve financial self-sufficiency through interest paid on loans. In many cases sufficient income is generated to also support other, non financial services, such as health. One of Freedom from Hunger's current initiatives, the Microfinance and Health Protection Initiative (MAHP), is working with five MFIs around the world to demonstrate, that when MFIs add health services, they not only advance their social missions (through improving health to reduce poverty and hunger), but also strengthen their financial and competitive positions. To evaluate this, we are looking not only at improvements in client health and related practices, but also at their ability to repay loans, increase savings, client satisfaction and loyalty, and the impact on the MFIs with respect to growth, cost recovery, profitability, and overall market position.

Opportunity to mobilize resources for health

Increased income and assets due to microfinance participation and the income generating activity it supports, enable women to put increased health knowledge to work by improving their ability to access primary care, medicines, essential health products, and

health microinsurance. Even small amounts of cash from earnings and savings can enable MFI clients to purchase insecticide-treated bed nets, transportation to the clinic to receive prenatal care or childhood immunizations, or to make small weekly microinsurance premium payments.

Role of women

Microfinance works primarily with women¹¹, who, in turn, have considerable influence on others in the same household when it comes to fundamental behaviors that affect health and social welfare. Frequently, these women indicate that their ability to borrow, save, and meet regularly with other women in their credit groups to learn about health topics such as maternal and child health, HIV/AIDS, malaria, and more, enhance their roles as decision-makers within the family and pave the way for important decisions, such as spending on food, health and education, and to change key health behaviors, such as child feeding practices, pre-natal care, and use of condoms.

Need for further scale and demonstration

Freedom from Hunger and its MFI partners are on the forefront of a growing movement to leverage the power of the global microfinance platform for integrated service delivery. In the face of the current challenges that threaten progress towards the MDGs, these efforts must be expedited to accomplish much greater scale and to realize the full potential as effective and efficient strategies to reach the most vulnerable. Achieving this scale will require global support for:

- Further demonstration of health innovations that can be feasibly and sustainably provided by MFIs, especially those who are reaching the poorest women and families;
- Massive replication of the most successful and highest impact innovations;
- Careful research to measure and document the impact on health, food security, and poverty reduction as further proof to the MFI, international health, and development communities of the effectiveness of integrating microfinance and health, and
- Promotion of integrated approaches via leadership briefings, statements of national policy, and advocacy through individual country development offices to signal the importance of applying this approach more widely.

Notes

- 1 From the 2009 ECOSOC high-level segment, 9 July 2009.
- 2 Ibid.
- 3 Ibid.
- 4 Ibid.
- 5 Kinsella and Velkoff, 2002

- 6 Ibid.
- 7 Daley-Harris, Sam. "State of the Microcredit Summit Campaign Report 2009". As of December 31, 2007, 3,552 microcredit institutions reported reaching 154,825,825 clients.
- 8 The Microcredit Summit reported that as of December 31, 2007 that 68.8% of clients taking out their first loan were "among the poorest". USAID's Microenterprise Results Reporting Annual Report" to the US Congress providing results on 31 reporting institutions using new poverty measurement tools, reports that on average 21.6% of the MFI clients in the USAID supported programs are very poor as defined by a per capita income of \$1.08 per day or less.
- 9 Market research study conducted by Freedom from Hunger in 2006 and described in unpublished monograph "Enhancing the Impact of Microfinance: Client Demand for Health Protection Services on Three Continents (Metcalfe and Reinsch)
- 10 See Freedom from Hunger's 2008 Annual Report at:
http://www.freedomfromhunger.org/pdfs/FFH_2008_AnnualReport.pdf v Daley-Harris, Sam.
- 11 Microfinance Summit report indicates 83% of MFI clients were women.

Chapter 6

TRENDS IN AID AND AID EFFECTIVENESS IN THE HEALTH SECTOR

Overview

This interactive panel discussion addressed recent trends in aid and aid effectiveness in the health sector. Against the backdrop of the financial and economic crisis, it gave the opportunity to discuss the role of aid in financing health systems, major challenges with regard to health care financing, such as alignment and predictability as well as scaling up successful initiatives to make aid more effective in the health sector.

Speakers agreed that, while there has been a continuous rise of development assistance for health (about 9 per cent per year on average), many national health systems are characterized by severe underfunding. There are various interrelated health challenges, including growing demand due to demographic changes, the rapid growth of non-communicable diseases and injuries, the shortage of health workers and the lack of health knowledge and literacy. This calls for mobilizing sustainable health care financing through Official Development Assistance (ODA) and other types of financing for development, improving the quality of such financing and emphasizing a multi-sectoral and integrated approach by governments, health partnerships, and non-state actors in delivering on national priorities.

H. E. Ms. Sylvie Lucas, the chair and moderator of the panel, underscored that the current slowdown of investment in public health infrastructure and the sharp decline in remittance and other financial resources would have multiple negative impacts on the lives of people.

H.E. Mr. Olivier Kamitatu Etsu, Minister of Planning of the Democratic Republic of Congo (DRC) emphasized that several diseases, notably HIV/AIDS, constitute a major obstacle to the human, social and economic development of Africa. In DRC, despite the Government's vision and efforts, the mobilization of domestic resources did not allow to reach the necessary budget to support the health sector.¹ A real issue is to see whether external assistance is efficient and responds to both the population's and donors' expectations. DRC decided to progressively refocus partner's actions under the coordination of sectoral ministries to avoid aid fragmentation, ensure a division of labour between different actors and guarantee a real alignment with national priorities. An effort has also been made to make aid allocation more transparent through the establishment of a platform allowing data collection on actual and future aid disbursements thus, allowing the Ministry of Health to get up-to-date information on the implementation of current sectoral assistance and on the mobilization of new external resources.

Mr. Anders Nordstrom, Director General, Swedish International Development Agency (SIDA), said that donors and other providers of development assistance must continue to take global responsibility for promoting global development, including social development and health. Donors and programme countries alike must pursue the Paris

Declaration on Aid Effectiveness, the Accra Agenda for Action and other aid agreements within the context of established aid policies of the agencies and national priorities of the programme countries. They must also honour the commitments on financing for development made at Monterrey and Doha. The key players, however, will always be national governments. Partnerships, including civil society organizations, are imperative for well-functioning health systems. They are the key to provide equitable access to health for all. Only by working together in a constructive partnership will it be possible to provide health services and empower those most in need, particularly in times of financial, economic and social crises.

Mr. Eckhard Deutscher, Chair of the OECD/DAC, emphasized that health is absolutely key to development, in general. This is evident from the importance of health issues in the MDGs. Aid to health has increased over the period 1980-2007 at about 9 per cent per year on average. Health has become a priority of bilateral donors' sector allocation. Aid effectiveness is geared towards improving aid quality, and ensuring better and sustainable results. OECD/DAC will keep track of progress and lessons learned from the health sector from an aid effectiveness perspective, together with key stakeholders, such as WHO, the Global Fund and NGOs. The DAC remains keen to work on and support progress in this area. For DAC members, it means not just improving the division of labour among themselves but also having a consistent approach across the boards of different organizations they are represented in.

Mr. Luis Riera Figueras, Director of Development Policy, European Commission, mentioned that applying the aid effectiveness principles is critical to reinforce the social role of the state and the universal access to basic health services. Health is fundamental to all dimensions of development. At the same time, development is key to ensure a supportive environment for health. The European Commission contributes to health in developing countries not only through direct support but also through general budget support, which represents a growing share of its ODA, particularly in Africa. This approach is based on the Paris Declaration principles of alignment and predictability, which are also fundamental to allow financing of the main components of the health sector, such as salaries.

H.E. Dr. Francisco Songane, Former Minister of Health, Mozambique, shared the data presented at the "Countdown to 2015" Conference in Cape Town last year on the analysis of aid flows for maternal, newborn and child health. According to the data, only 6 per cent of ODA funding was channeled through the existing country mechanisms and to fund the overall country programme. The remaining 94 per cent were channeled outside the Government's control and went to specific projects. The Paris Declaration had been reaffirmed last year in Accra by the adoption of the Accra Agenda for Action. There is an urgent need for a change of attitudes and for encouraging upstream policy development rather than short-lived charity-based interventions.

Ms. Helen Evans, the First Chief Executive Officer of GAVI, recalled the five principles of the Paris Declaration on Aid Effectiveness: namely, country ownership, alignment, harmonization, managing for results and mutual accountability. New initiatives were also underway to accelerate efforts to reach the MDGs. These include the GAVI Alliance

and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which were having a significant impact on the way aid for health is delivered.

Following the presentations by the panelists, the lead discussant, Ms. Marta Monteso Cullell, Coordinator of Action for Global Health, noted that the speakers had identified, as key issues improving aid effectiveness, including managing for development (and health) results, coordination, mutual accountability, country ownership, alignment, simplification and harmonization and results-based approaches. She stressed the need of a paradigm shift among donors from charity-based fragmented technical cooperation to upstream policy advice and institutional capacity development in national health services.

Key issues emanating from the interactive discussions included:

- Promoting the health agenda, particularly in fragile countries, is fundamental to achieve sustainable development and the MDGs.
- There is now recognition of the key importance of national ownership and alignment with national priorities. The concept of national ownership goes beyond the government stewardship and must include civil society, stakeholders and citizens in need.
- In the health sector, it is critical to devise sustainable national (public) system and financing mechanisms (e.g. tax-based, social insurance scheme, etc.) towards universal health coverage. ODA and external assistance in health should shift from the current charitable technical cooperation projects towards upstream support to strengthening the national health system and supporting institutional capacity development.
- The Paris and Accra agreements formulated a set of guidelines on aid effectiveness, but more could be done in the future to follow up these guidelines in the health sector and the social sector.
- The aid environment is continuously changing. Regardless of the recent scaling up of aid for health, the activities in the health sector are fragmented, with too many actors involved. There should be more effort to reduce fragmentation and increase harmonization.
- It was considered that global initiatives in the health sector provide good practices and lessons learned on aid effectiveness.
- In health service delivery, public-private partnerships are vital. The role of parliamentarians, civil society and local governments is critical to devise bottom-up and inclusive health policy to ensure health service access for those in need.
- In order to achieve the MDG in the health sector, the volume of aid flows must be scaled up regardless of the current crises. Timeliness and predictability should be ensured.

Priority should be given to ensuring institutional capacity development in the area of health, with special focus on gender equality and minimizing urban-rural disparity in the delivery of inclusive health services.

Aid and Aid Effectiveness in Democratic Republic of Congo²

By H.E. Mr. Olivier Kamitatu Etsu
Minister of Planning
Democratic Republic of Congo

As a person from a post-conflict country, I appreciate the theme of this panel. It is particularly relevant in a situation where all efforts must be mobilized to both respond to daily emergencies and engage in development at the same time, including combating several diseases, notably HIV/AIDS, which constitute a major obstacle to the human, social and economic development of Africa. In the Democratic Republic of Congo (DRC), as in all fragile states, peace keeping and government strengthening are the key points of public action and intervention. Among the many issues that we face today, the issue of financing of the health system is one of the main concerns of the government. In the health sector, DRC mobilizes domestic budgetary resources in providing basic and quality health care services, improving the health of all the population through an acceleration of the fight against the most deadly diseases, rationalizing management and ensuring equitable repartition of resources, developing the Strategy for Strengthening the Health System (SRSS) to rebuild primary health care and strengthening the Ministry of Health's leadership in coordinating development partners in this sector.

Despite this vision and government priorities, the mobilization of domestic resources did not allow the government to reach the necessary budget to support the health sector. Domestic resources represented only 3 per cent of all budgetary resources in 2007 and 2008, that is to say less than 1 per cent of gross domestic product (GDP). Regarding the impact of the support provided to the health sector, some elements can be found in DRC's national MDGs progress report for 2009. First, despite the fact that child mortality of children below one year remains a concern in DRC, the implementation of the Enlarged Vaccination Programme (EVP), led to some progress in reducing child mortality. This slight reduction, which started at the beginning of the 2000s, continued in 2007. The rate has dropped from 148 per 1000 in 1995 to 98 per 1000 in 2007. However, children in rural areas still have less chances to live beyond their first year. Second, improving maternal health remains a major challenge in DRC, whose maternal mortality rate is one of the highest in the world. To respond to this situation, DRC benefits from support in implementing the Rural Health Programme (SANRU) financed by the United States and the National Programme for Reproductive Health (PNSR) financed by UNFPA and UNICEF. Third, the fight against HIV/AIDS, malaria, tuberculosis and other diseases received support from several donors, including the IMF, World Bank, Belgium, UNDP and UNICEF. This support contributes to improve the health of Congolese people but more efforts are needed. To respond to the shortage of domestic financial resources, DRC benefited from financial support for 195 projects and programs to be implemented in 2006-2012. More than 90 per cent of financial assistance in the health sector comes in

the form of donation, such as emergency assistance, humanitarian assistance or development assistance.

In 2007 and 2008, financial support from more than 20 partners, excluding NGOs and private sector, to the health sector reached US\$347.88 millions. 90.22 per cent of these resources come from seven donors, including the IMF, Belgium, the World Bank, the United States, the European Commission, the United Nations and the United Kingdom.

The health sector is one of the sectors receiving support from the most important number of partners. Therefore, it is important to ask whether the assistance is efficient. Is it responsive to the needs of the population? Does it meet donors' expectations? What are the ways to improve the living conditions of the Congolese population? DRC is firmly engaged in a partnership based on a growth and poverty reduction strategy (PRSP), which constitutes the unique framework for donors, government and partners. As part of this effort, the DRC adopted a priority action plan to ensure the transition between the emergency phase and the sustainable development phase in DRC. The development assistance framework adopted by donors responds to government priorities namely: (i) stabilize security in the East, (ii) improve the socio-economic situation and (iii) reach the Heavily Indebted Poor Countries (HIPC) Initiative completion point.

Recently, in a high-level forum on aid effectiveness organized in Kinshasa, the Government, partners and civil society have measured the challenges ahead and underscored the necessity to place more emphasis on coherence, coordination and complementarities. This exercise allowed us to measure the level of aid and its adequacy to national priorities, perceive sectoral strategies, particularly in health, education, justice and rural development and reflect on coordination and follow up. Among the different road maps presented, health sectoral policy received particular attention.

With regard to external aid mobilization for health and other sectors, DRC decided to progressively refocus partners' actions under the coordination of sectoral ministries to avoid sprinkling targeted financial support and aid fragmentation, ensure a real division of labour between different actors and, above all, guarantee a real alignment with national priorities. In order to ensure predictability of aid, the DRC agreed with partners to use sectoral ministries as aid delivery channels as opposed to implementation agencies, as used in the past.

Aid effectiveness remains a concern for the Government and the donors alike. If the effects of the financial crisis were to stay, we have to be realistic and offer clear responses to a possible reduction of ODA. In DRC, an effort has been made to make aid allocation more transparent with the support of Belgium, France and the United Nations. The Government has now a platform to manage aid and investment hosted by the Ministry of Planning, allowing data collection on actual and future aid disbursements. Beyond transparency, predictability remains a major challenge for a transition state. On the basis of the lessons learnt from this first information system, several partners have decided to refocus their actions, prioritize their interventions on the basis of relevant sectoral priorities and improve coordination. For instance, Belgium and the World Bank decided to focus their support on sectors where expected results would allow the DRC to overcome more quickly the obstacles preventing it from achieving the MDGs. This

platform will allow the Ministry of health to be constantly updated on the implementation of current sectoral assistance and on the mobilization of new external resources.

Reducing poverty calls for better coordinated action between partners and governments. Why is aid in DRC not as effective as we would wish it to be? The reasons could be the immensity of the country, weakness of capacities, absence of dialogue, coordination, implementation and control issues, or weaknesses in the leadership. The perspective of peace in the Great Lake region is an opportunity to seize. My country is in peace with nine neighbors. In maintaining our efforts to keep this peace and strengthen the state, we can now focus our common actions on giving back the Congolese State its dignity, which all Congolese are aspiring to.

Trend in Aid and Aid Effectives in the Health Sector: OECD/DAC Perspective³

By Mr. Eckhard Deutscher

Chair of the Development Assistance Committee DAC/ OECD

Aid effectiveness is geared towards better and sustainable results. Health results matter greatly because progress in health is the key to development, as illustrated by the relative importance of health amongst the MDGs⁴ Progress towards the MDGs remains uneven, as recently demonstrated by the last World Health Statistics and the report from the Global Campaign to salvage the United Nations' Health goals. In many Sub-Saharan African countries, the national HIV/AIDS prevalence rate has either leveled off or decreased. But maternal mortality rates remain very high in the same region, where the proportion of attended births by skilled personnel increased only slightly. In this context, it is timely to ask what has been, and what should be OECD/DAC's contribution to a more effective aid.

It is true that aid to health has significantly increased in the past years but this is not enough. After stagnating in the 1980s and 1990s, aid to health has risen sharply: ODA for health amounted to USD 5.5 biennium in 2000-2001, and USD 13.5 biennium in 2006-2007. On average, aid to health grew over the period 1980-2007 at about 9 per cent per year, a very significant increase. It has also increased in percentage of total ODA⁵ Health has clearly become a priority of bilateral donor's sector-allocable aid. Yet, more funding is needed in order to reach the internationally agreed goals for health and HIV/AIDS. The Japanese and Italian Presidencies of the G8 countries also undertook an accountability exercise – the so-called Tokyo Framework for Action on Global Health – in order to track and report about the G8 commitments for global health. The OECD provided technical advice to the health expert group.

Last September, a High-Level Task force on Innovative Financing for Health System Strengthening (HSS) was set up, with the objective to help deliver extra money for delivering the MDGs 4 and 5. Its final report includes proposals, which “could mobilize up to 10 billion USD per year until 2015”, using both ODA and non-ODA sources, traditional aid and innovative financing mechanisms.

Bilateral and multilateral agencies and partner countries need to address key challenges. The first step is to maintain financial support for health despite the financial crisis. The current financial crisis will increase pressure on donor aid budgets and on budgets in partner countries. To minimize these risks and to secure funding for health financing/health systems, the DAC, within the broader OECD crisis response, has reacted to the financial crisis, in close coordination with key partners, such as the World Bank and United Nations organizations. In a recent DAC meeting, we shared the most updated analysis about the potential impact, particularly the human impact of the financial crisis in the poorest countries, using analysis from WHO, in particular. DAC members have reaffirmed their existing ODA commitments. They recognized the need to tackle the

crisis with all instruments available, including non-ODA traditional sources of funding. Synergies between these different instruments also need to be exploited, so that overall financial flows are sustainable for partner countries.

In developing countries, donors should also clearly advocate against cuts in country health spending and support countries reforms for building and expanding social protection/health protection schemes - whether it derives from tax or social health insurance - to protect the poorest against the impact of the crisis. As rightly stressed by WHO, the crisis can create an opportunity to reform countries' financial and delivery systems, in line with the objective of universal coverage, with the support of aid. Finally, countries must be encouraged to progressively increase their domestic resources for health.

Second, we need to rationalize the health architecture. Here are three illustrations: to monitor global initiatives, to clarify the division of labour on health system strengthening and to support effective and accountable new forms of funding for health.

It is well known that the health aid architecture has become complex with more than 90 global health partnerships. Between the second half of 2007 and September 2008, I could count not less than five global health initiatives⁶. It is time that we stop this "initiative-itis" and undertake a rigorous monitoring of ongoing initiatives and partnerships, looking at their impact, added value and costs for the global health community, including for multilateral agencies that host some of them.

Multilateral agencies and global programmes have again highlighted the importance of health systems to deliver results. As stressed in the OECD Development Cooperation Report 2007, clarifying the division of labour across key stakeholders in the area of health system strengthening is critical. We are pleased to see that there are ongoing discussions to achieve this objective. We hope that all organizations which play a critical role in funding and supporting health country systems and the partner countries can agree on concrete and operational solutions, which make the most of current increasing investment in health systems, in line with country priorities and needs. The OECD remains interested to support and report about progress in this area. DAC members need to effectively accompany the process by being consistent across the boards of the different organizations they are represented in.

Health has concentrated the bulk of innovative financing mechanisms since 2006: the International Finance Facility for Immunization, UNITAID to fund drugs for AIDS, TB and malaria, the Advanced Market Commitments to scale up access to qualitative vaccine, the ProductRed brand, which supports the Global Fund's activities. There is now a range of mechanisms which can bring added value for countries and health outcomes. It is important to make sure that new ideas do not translate in new mechanisms/institutions, which would generate additional transaction costs and increase the level of aid spent through technical assistance in support to these additional programmes and less in support of long-term country programmable aid.

Proliferation of aid mechanisms and institutions complicates accountability. More aid should go with clear accountability and transparency. This is a key to maintain the public support to aid to health.

The third challenge is regarding country ownership. Strengthening country ownership remains the most critical condition for effective aid and sustainable results. More than the Paris Declaration, the Accra Action Agenda stresses the utmost importance of country ownership, strengthened by a broad country dialogue and domestic accountability, also supported by aid aligned within country priorities, systems, budgets and institutions. Moreover, the Paris and Accra frameworks require that all development partners, including global programmes and funds, use and strengthen country information systems and improve the medium-term predictability of their aid so that countries can plan and develop sound, well-funded and realistic strategies.

Here are examples of what this means in the health sector. The first one is reducing aid fragmentation in countries. The landscape in health aid can be very complex at the country level. In a country like Cambodia, there are above 100 health development partners including international NGOs. How can one government possibly manage such a number of partners, most of them being involved with small-scaled projects? A degree of diversity of actors is sometimes necessary to cover all country priorities (for instance, not all donors are ready to fund family planning activities or very technical activities). But, we need to keep in mind that capacities to manage, monitor and report about these various aid activities are limited. At the same time, I would like to stress that the need for a better division of labour among donors should come with a collective responsibility and action to address the needs of all countries, including the ones in fragile situations, which face the most critical challenges.

The second example is supporting health policies that are inclusive and accountable. Donors can play an effective role in supporting health policies that are inclusive and accountable. They can contribute to strengthen local accountability through good health information systems, support to local technical or community-based monitoring and evaluation of health policies. There are positive examples. In districts of Tanzania, for instance, the Health Metrics Network has supported the development of information systems on disease and the cost effectiveness of specific interventions to address child mortality. The information then helped the districts achieve a 40 per cent reduction in infant and child mortality over three years, with only an 18 per cent increase in the investment for health.

The Global Fund has also contributed to better country ownership and community participation through the creation of the Country Coordination Mechanisms (CCMs), which ensure the participation of people living with AIDS in the policy decision process.

The third example is supporting long-term institutional development in health. The issue of technical assistance, which accounts for a significant part of the ODA to health⁷, has been recently brought back in the debate on health aid. In Accra, partner countries stressed the need for technical assistance to be demand-driven, transparent and accountable. The High-level Task Force on Innovative Financing recently asked the OECD DAC to undertake a reflection on technical assistance. We will contribute from an aid effectiveness perspective, focusing on a long-term institutional development perspective, asking ourselves about best practice and possibilities to support communities of practices, and regional platform.

The fourth example relates to supporting strong leadership and vision. In DRC, leaders were able to formulate a strategy for reform that successively focused on strengthening the district model, managing the donor fragmentation, which was very high, setting up structures and networks for collaboration and negotiation with partners and increasing the public funding for health.

Mali has updated its vision for scaling up to the health MDGs (PRODESS 2) with clear and monitorable results indicators. IHP+ compact⁸ has been signed between Mali and almost all donors. It includes a regular mechanism to monitor the fulfillment of mutual commitments, including, for donors, a commitment to provide more predictable and aligned aid. This is a promising way and we hope that more donors, including those who confirmed their commitment to the IHP+ at the global level, will be able to join this process.

The fifth example is going further in alignment and predictability and sharing lessons beyond health. Global programmes and funds account for a significant part of aid to health in many countries. In AIDS, tuberculosis and malaria, the Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR) are sometimes the only external source of support to countries programmes to fight these three diseases. This raises the issue of aid dependency. It also makes it even more important that these funds are reported on budget and are predictable, and that these programmes use countries systems, including the procurement and public, financial and auditing systems. Progress is underway. The Global Fund, for instance, has taken seriously its commitments and support to the Paris Declaration. It plays an active role in the Working Party on Aid Effectiveness, it has contributed to the Paris Declaration monitoring surveys and through the global programmes' learning group and it aims at promoting best practice and progress, particularly in the area of alignment. I would like to note more particularly the decision taken by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to fund health strategies instead of country proposals, which marks a very important and promising change. Other improvements are also being considered like new policies for funding salaries, in countries in order to align with in country policies, in order to avoid distortion effects. These changes need to be reported and shared widely, so as to guide potential new developments in sectors other than health.

Through an increasing and quite exceptional mobilization for health, there is now a quite comprehensive aid package in health for countries to build on. The challenge is to help countries to manage the diversity of options within their political and cultural settings and within their own strategic development frameworks. The challenge is also to provide evidences of what works and to learn from both positive and negative experiences, including through regional and south-south cooperation, so that countries can design and develop appropriate solutions.

European Commission's Approach to Enhancing Aid Effectiveness in the Health Sector⁹

By Mr. Luis Riera Figueras
Director for Development Policy
European Commission

Health is an important issue in the context of development policy. Applying the aid effectiveness principles is critical to reinforce the social role of the state and the universal access to basic health services, the most concrete translation of respecting equity in the right to health.

The Palais des Nations witnessed the global commitment to the right to health, as was defined 60 years ago in the Universal Declaration of Human Rights, where Article 25 relates to the right to medical care and the right to security in the event of sickness and disability, while motherhood and childhood are entitled to special care and assistance. Sixty years old, and cannot be more relevant in today's world.

However, besides the rights' dimension, there is overwhelming evidence that investing in health pays off in economic growth through productivity. But less-known and probably of larger and more profound impact is the effect in terms of learning and educational gains of well-nourished and healthy children, the basis for a strong new generation owning their own future. Health is, hence, fundamental to all the dimensions of development. Development is the key to ensure a healthy environment and reduce the risks of ill health and burden of health care demands.

Still, however, health in developing countries is, overall, close to stagnant in the countries with worst health indicators and lowest domestic public financing capacities, especially in Africa. Experience has shown that economic growth alone has not correlated with poverty alleviation and progress towards the MDGs. The present financial crisis is a clear proof that economic growth on its own does not guarantee sustainable development and social cohesion. We need to balance continued and sustained growth with greater equity to ensure that growth benefits the entire population.

I would like to highlight in this context that, with the Commission's package on supporting developing countries in the context of the current crisis, we have proposed a special financial envelope to secure health and education expenditures for those countries experiencing higher financial difficulties.

There is a strong correlation between the levels of public funding for health and the access to basic health care services, especially for the poor on the one hand, and the sustained progress towards health MDGs, on the other. Clearly, public financing is not the only and often not even the main factor influencing health but, in most of the countries, it is a pre-condition for equity of health care and health indicators. Mainly due

to the large mobilization of funds to confront HIV/AIDS, the levels of health ODA have tripled in this decade.

However, this increase has brought one of the main challenges in the health sector at the country level: a large proportion of health ODA is fragmented in a myriad of often disconnected initiatives and which are far from sector dialogue principles and the Paris and Accra commitments on alignment. Besides this fragmentation, health ODA is highly volatile and has very low degrees of predictability.

We see with great hope the recently adopted resolution on primary health care and strengthening health systems at the World Health Assembly. It reaffirms the Alma-Ata principles, with a wider understanding of primary care as the equitable and universal access to comprehensive health care, and with a clear framework of commitments to secure national and external resources in aligned, effective and sustained ways.

We are full of expectation on the leading role of WHO in concretizing this challenge in the action plans on inclusive leadership, universal coverage, patient-centred approach and health-in-all policies. We are also convinced that today's ECOSOC Ministerial Declaration will help in pushing this process forward.

In this global context, we need to consider the role of the EC and, more importantly, the EC added value. While we continue to have a leading role in many fragile contexts, if we only focus on direct support to health, we will get a biased picture of the EC's contribution to health in developing countries.

This is so because our policy, particularly in Africa, is to provide increasing share of ODA through general budget support. This is based on its value in the context of the Paris principles on alignment and predictability. These elements are also fundamental to allow financing the main components of the health sector: the recurrent costs of salaries, medicines and decentralized management.

We need to support health systems with public financing, which can ensure equitable access to comprehensive basic health services prioritized in the countries and not in New York, Geneva or Brussels, and facilitate the participatory analysis and the setting and rolling of those strategies in close dialogue with them.

In the framework of our participation in global initiatives, such as the Global Fund and GAVI, we actively encourage these initiatives to move beyond a strictly disease approach and to gradually support wider health system challenges. Our focus on budget support does not imply that we do not look into global problems that deserve global actions. Regarding health systems, we will give more attention and greater coherence in addressing migration and human resources for health and trade and access to medicines.

In this regard, let me respond to the observation in India's Honourable Minister of External Affairs' intervention yesterday regarding the seizing of generic drugs in transit in European ports. I would like to assure the Indian authorities that we are following up these issues in a comprehensive manner. Today, the EC has released the annual report on EU customs' enforcement of Intellectual property rights. It shows that there are reasons of concern in the traffic of counterfeit medicines, which pose a risk for the health of population in developing countries. However, ensuring access to affordable medicines in

developing countries remains an unwavering commitment of the EU. We agree that customs action against counterfeit and substandard medicines should not hamper the legitimate trade in genuine, generic medicines.

We believe that the increased scale, greater predictability and better alignment of EU aid will encourage sound policies and adequate financing to ensure equitable access to basic services, including health. We also look forward to enhancing the level and depth of development and sector policy dialogue so as to effectively link general budget support with the desired progress towards MDGs.

In this context, the EC recognizes the International Health Partnership (IHP) as the reference framework to advance in the commitments to aid effectiveness in the area of health. The IHP has the potential, by updating the principles of Sector-Wide Approaches (SWAP) in today's aid architecture, to facilitate higher levels of health development aid, and more ownership, alignment and predictability of aid. But, all donors should, at any price, embark on a unique and coordinated process of joint assessment of national strategies. Otherwise, the IHP process will not fulfill its high expectations.

We already know the relevance of health as a priority. We acknowledge the sense of urgency of those 10 million children neglected from their chance to live, due to an insulting inequity in global resources for health care. We are committed in the EU to set the comprehensive policy as long as is needed, to work in trustful but frank partnership with developing countries and to mobilize the commitments, that we are bound to. We believe in it. And we will facilitate the essential role that Europe will play in this renewed challenge.

A Case Study of Aid and Aid Effectiveness in the Health Sector in Mozambique¹⁰

By H.E. Dr. Francisco F. Songane
Former Minister of Health
Mozambique

The world has come together in 2000 to announce the Millennium Declaration as an expression of consensus on the urgency to act and address the critical issues behind the extremely poor living conditions of 1.2 billion people. The Millennium Development Goals (MDGs) are the guiding document on what to be achieved with targets and indicators to monitor progress. The MDGs are ambitious, commensurate to the depth of the crisis that the affected countries cannot deal with alone. Solidarity and collective effort were, from the outset, regarded as key pillars in the efforts to meet the targets; the need for the world to truly come together to ensure that the countries in need do move quickly from the substandard living conditions to set a platform for development.¹¹

Now, halfway through the 2015 targets, we realize that, although progress has been made, most of the countries will not meet the targets unless an extraordinary and effective effort is made to address the critical issues. Health is a key for development, as healthy people are better fit for income generation and contribute to savings by avoiding the continuous and often high expenses with health care. On the other hand, the health indicators are a good gauge to assess the socioeconomic status of populations and, ultimately, the development of a country. The health-specific MDGs are the furthest lagging behind, and the majority of the most affected countries are not making progress at all. The analysis done by the countdown to 2015 to assess progress towards the MDGs 4 and 5 - child and maternal health respectively - revealed that among the 68 countries studied, and accounting for 97 per cent of all maternal and child deaths, only 16 countries are making good progress to meet the target on MDG 4, with MDG 5 showing an even worse scenario, where only three countries have low levels of maternal mortality and are judged to be on course to meet the target.¹²

There are many reasons for this very slow progress and the way aid is delivered is one of them. The countries in need do not have sufficient resources to properly fund their health programmes. The average spending on health per capita per year in low-income countries is US\$ 16, as compared to US\$ 2,672 in high-income countries. These US\$ 16 encompasses total spending, public money, grants and out-of-pocket expenditure, which, in many countries, constitutes the bulk of the contribution. Taking the example of Burundi, one of the countries with the lowest per capita spending on health, US\$ 2.90, the Government contribution to this figure is only 70 cents; therefore, a per capita public spending on health of US\$ 0.70¹³ This is a country with high levels of maternal and child mortalities and a coverage of the health services of only 34 per cent, judging by the coverage of skilled attendance at birth.¹⁴ The Commission on Macroeconomics and Health calculated a minimum expenditure of US\$ 30-40 per person per year on health to guarantee basic services. This figure was now updated by WHO to US\$ 35-50. This is a

huge discrepancy between what is required and the capacity to provide the resources and eventually deliver the services. This situation is prevalent in dozens of countries with the worst indicators. There is donor assistance but still with some problems that hamper the effectiveness of the effort. In the same country, Burundi, only 44 per cent of the disbursements are on schedule and recorded by the Government, and most donor missions (87 per cent) are not coordinated in a total of 275 missions in 1 year.¹⁵

A case study of aid effectiveness in Kenya highlighted volatility and fragmentation of foreign aid and its consequences, namely, the high transaction costs; again with multiplicity of missions and reports and the pressure on the country's limited capacity to cope with many projects. Staff find themselves in a situation of responding to several donor projects and requirements and neglect their other responsibilities. The other element resulting from poor donor coordination, which erodes the little domestic resources, is the requirement for counterpart funding or future financing without giving the country sufficient time to plan for that and assess its viability.¹⁶

In order to have progress, it is crucial that the different players involved are well synchronized, working as one with a long-term perspective; if the political commitment is not maintained internally and the external aid is not sustained and, at least at the same levels, the gains can be lost or reversed.

It was with this kind of scenarios on the backdrop that in 2005 the Paris Declaration on Aid Effectiveness was signed and regarded as a major landmark, setting a new era in the relationships between countries in delivering aid for development. The Paris principles spell out the "rules" of engagement and focus on the country programme as the guiding document for all the activities. They emphasize partnership for development rather than mere time-limited interventions undertaken according to circumstances. In fact, a new thinking emerged, a momentum was created that opened the perspectives of developing countries to see their concerns addressed and embark on a development plan, moving away from the hectic and unproductive routine of preparing proposals, receiving missions and submitting reports.

Improvements on the way international aid is delivered have been registered but at a small scale far from the high expectations created with the signing of the Paris Declaration. There was consensus in Paris and the terms on how the business should be conducted agreed upon, and targets were set to monitor the pace of change to fulfill the principles with the year 2010 as a reference. However, the reality is not encouraging as the change of the situation is not fast enough and the good environment countries in need were hoping for cannot be guaranteed. The report published last year on the survey on monitoring the Paris Declaration revealed that the key principles are not being fulfilled and the project approach focused on the donors' agenda is very much the current state of affairs.¹⁷

The following chart highlights the progress on the main indicators.

CHART 1.1: How far are we from meeting the targets? (33 countries)

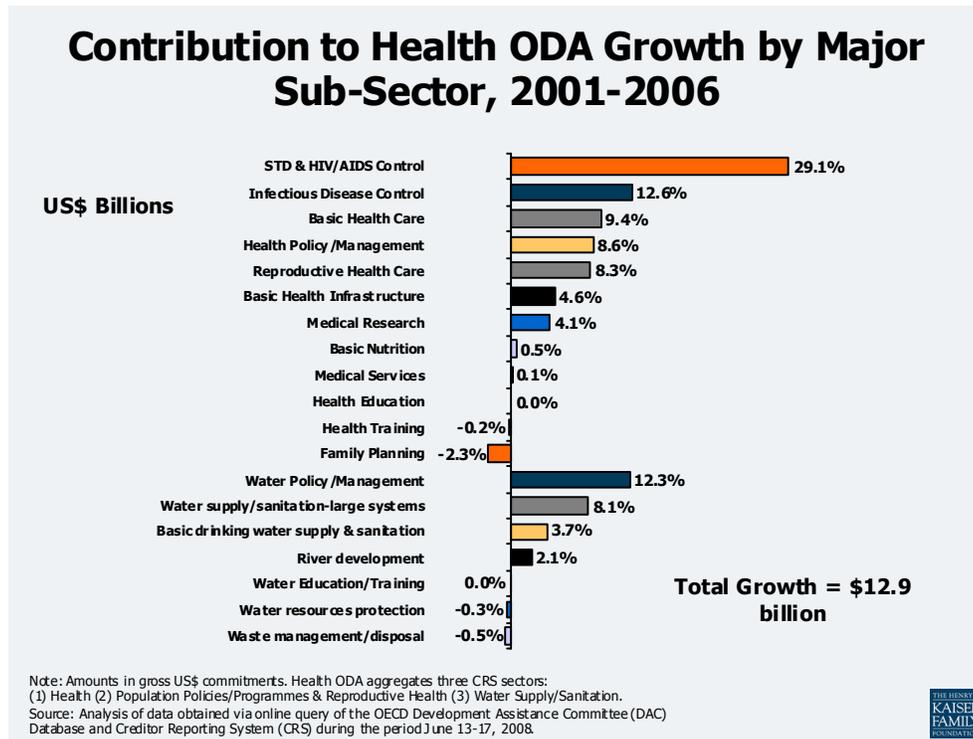
Indicator	2005 baseline		2010 targets
1 Operational development strategies	17%	24% ← Distance to target (in 2007) →	75%
2 Reliable public financial management (PFM) systems	—	36%	50% of countries improve score
3 Aid flows are recorded in country budgets	42%	48%	85%
4 Technical assistance is aligned and co-ordinated	48%	60%	50%
5a Donors use country PFM systems	40%	45%	(80%)
5b Donors use country procurement systems	39%	43%	(80%)
6 Donors avoid parallel PIUs	1 817	1 601	611
7 Aid is more predictable	41%	46%	71%
8 Aid is untied	75%	88%	Progress over time
9 Donors use co-ordinated mechanisms for aid delivery	43%	47%	66%
10a Donors co-ordinate their missions	18%	21%	40%
10b Donors co-ordinate their country studies	42%	44%	66%
11 Sound frameworks to monitor results	7%	9%	35%
12 Mechanisms for mutual accountability	22%	26%	100%

Source: 2008 Survey on Monitoring the Paris Declaration- 3rd High-Level Forum on Aid Effectiveness

We are not yet in partnership for development and the agenda still very much skewed towards the donors; it is not the country strategy for development that is addressed but what the country can get from the set of priorities chosen by the donor. Furthermore, the conditions under which aid money can be utilized are tight, limiting further the room for maneuver by the country authorities. Similar findings were reported at the “Countdown to 2015” Conference in Cape Town last year on the analysis of aid flows for maternal, newborn and child health: only 6 per cent of the ODA money was channeled through the existing country mechanisms and to fund the overall country programme. The other part, 96 per cent, not only was outside the Government’s control but also went to specific projects.¹⁷

International funding for health (including nutrition, water and sanitation) increased considerably in the last 20 years, having risen from 7.2 US billion in 2001 to 20.1 billion in 2006. Analyzing the distribution of these resources, it stands out that the disease - specific funding supersedes other investments, where funding for HIV/AIDS is four fold that of maternal and child health, and a similar gap when comparing the overall infectious

diseases control with basic health infrastructure. The crucial area of personnel training received less than 1 per cent of the resources.¹⁸



Source: The Kaiser Family Foundation

It is correct that the diseases which contribute to high burden in populations receive attention but the actions have to be in the context of the overall challenges faced by the health sector. For instance, maternal, newborn and child health, which, together, have yearly death toll of 10 million are not benefiting from the large sums indicated above. In the case of maternal health, there is tiny progress with stagnation in Sub-Saharan Africa in the last 20 years. This area requires a functioning health system that has benefitted from very little resources so far. The plight of maternal, neonatal and child health has galvanized new thinking and now there is a consensus that, unless the countries have functioning health systems, it will be extremely difficult to improve the health indicators and sustain the actions initiated by taking the opportunity of accessing resources generated through international initiatives. If a country is able to provide skilled care at birth to most of the pregnant women and offer a caesarean section when the need arises in a timely manner and performed with the required quality by a properly trained person, that country has a reasonable health system able to deal with other health problems. This is the way forward and the consensus has to be consolidated.

We can do much better and we need to move quickly. The Paris Declaration has been reaffirmed last year in Accra by the adoption of the Accra Agenda for Action that

outlines what to do from the recipient countries through the international institutions up to the donors.¹⁹ The main message is the need to change the attitude and adopt a posture of engagement for development rather than short-lived interventions for charity. International awareness about the importance of health in development is now high and considerable resources have been made available. However, the problem lies in the way funds are channeled and utilized; it is the donors' and international initiatives' priorities that determine what the money can be used for and how to use it. There has to be a shift in the approach to address the country development strategy instead, get stability in the country and stop the cycles of new plans, as there are new initiatives. This is what is called for in the Accra Agenda for Action. It is imperative that the countries get ready, invest in capacity building and retaining it, and have the development strategies ready. Political drive from the appropriate levels, complemented by consistency in decision making, is paramount for the countries ownership and positioning of the Government to lead the process. Coordination among the different Government departments has to be structured and the functioning of the ministries guaranteed with well-trained staff in place. Stability is critical; ministers can change but the lead officials in the ministry and down the hierarchy should be managed differently. Without stability in ministries and the whole Government machinery, the likelihood of keeping the vision and strategy for development will be slim. Consistency in the implementation of programmes and good monitoring are crucial for the improvements of indicators. Certainly, and it is not desired, this does not mean advocating for long tenure in office but the high turnover we are witnessing in many countries is one of the weaknesses and a contributor to the ineffective use of resources.

Globally we need a good synchronization of the different sources of funding and eventually work towards aggregation of funds. If the country development plan is the document to guide the activities by the different partners, our success should be measured against the goals set for the plan. The Accra Agenda for Action should be adopted by the governing bodies of the different initiatives, which should have their institutional frameworks and *modus operandi* adjusted accordingly. If the problems were identified and the solutions found and agreed upon, it is imperative that all the partners do implement what is proposed in the solutions, which is "how to make the "Accra Agenda for Action" binding to all and how to exert accountability at all levels.

GAVI Alliance and Global Health Initiatives: Approach to Aid Effectiveness in the Health²⁰

By Ms. Helen Evans
Deputy Chief Executive Officer
GAVI

The Paris Declaration, which was adopted in 2005 by over 100 countries and aid agencies, was the result of several years of lessons learned from the experience of managing aid and negotiations to reach consensus on what were the fundamental tenets to ensure that aid is as effective as possible. Along with the Paris Principles, new initiatives were also underway to accelerate efforts to reach the Millennium Development Goals; the GAVI Alliance (the Global Alliance for Vaccines and Immunization) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. These were the two global health initiatives that had a significant impact on the way health aid is delivered.

It is not surprising that the business models and approaches of the Global Fund and the GAVI Alliance encapsulate core Paris Principles. With almost ten-year experience, GAVI has had the opportunity to reflect on the experience of putting the Paris Principles into action through the Global Health Initiatives. This, however, does not mean that the Funds can be the answer. There is room for improvement and, as a learning organization, we seek to reflect, learn and change our practices and procedures. Increasingly, in recent years in the health sector, we have seen a commitment to work collectively to improve aid effectiveness.

In this respect, the International Health Partnership is an important step, but it still needs to demonstrate outcomes. It has to shift its focus to the specifics of the problems that countries face in dealing with multiple demands of external partners and it has to deliver results in, and for, the people in the country. We need behavioural change from all parties that results in lower transaction costs for countries and delivers results. GAVI and the Global Fund business model reflect the Paris Principles in the following way.

Country ownership

The first step is consideration of proposals sent to us by countries. It is a country-led approach. This could be taken as a simplistic interpretation of country ownership but, nonetheless, the basic tenet of the business model is that we respond to the proposals received from countries, including their objectives and targets. Country ownership must be the starting point, not the end point. The important thing is that country ownership does not necessarily equate directly with government ownership. Governments have a critical stewardship responsibility but the clear experience from GAVI and the Global Fund is that governments, on their own are not the answer. Civil society, including the private sector and faith-based organizations, has a critical role to play in ensuring results.

The principle of alignment of processes and practices with national processes

The clearest example of GAVI is alignment of our support to the country planning cycle. Whether for a new vaccine or for health systems strengthening support, we match our financial commitment to the duration of the country plan. If a country has a three-year health plan, or a five-year comprehensive multi-year immunization plan, then GAVI's support will match it - for three or five(or more) years. We have further work to do. For example, Geneva centrally-established timeframes for grant performance review work against full alignment.

Harmonization

Michel Kazatchkine said "the global health initiatives are an example of upstream harmonization". Avoiding or substituting for a potential multiplicity of donor government grants and the associated reporting demands on countries is surely a core objective.

One of the principal Paris declaration tenets that the global health initiatives have embraced fully is managing for results. The focus of our work- and the area for which we at the Funds are held accountable by our donors - is results. But, it should be clarified that, managing for results is a concept that applies not only to donors but also a basic principle of good governance that taxpayers expect from all governments. As financing instruments, GAVI and the Global Fund have a perspective as both a recipient of funds from traditional donor community and as a grantor of funds.

There is also a challenge for bilateral donors; they need to look closely at the demands that they place on the recipients of their aid. Is it clear that the accountability they demand of us is essential to achieve the results, the development outcomes? Were the 752 aid missions to Vietnam in 2007 really essential? We must be able to do better than requiring reports on 600 (and more) health indicators in Rwanda.

The development community has learnt important lessons on what works and what does not. As we move forward, we need to build on these experiences to ensure that what we do is as effective as possible. We know that, in many countries, the health systems are weak and a fragmented health sector is inefficient. Minister Tedros from Ethiopia once said the following. "Our vehicle has not been strong enough to carry all the programmes we have loaded on it. Now, we are working to strengthen the vehicle so that it can carry our programs, the vaccines, and the other health-care interventions, to every corner of this vast country."

One small step towards decreasing the fragmentation is the work that we are doing with others to facilitate more streamlined external financing to countries, while retaining the focus on results. The International Health Partnership is an important step forward but needs to demonstrate outcomes. It has to shift to focus on the specifics of the problems that countries face dealing with multiple demands of external partners.

The GAVI - the Global Fund to fight AIDS, tuberculosis and malaria - and the World Bank are currently working towards joint programme support for countries' health system development. The idea is harmonized channels of finance to support countries' national health plans and strategies. This will build a common assessment of strategies,

with better aligned monitoring and evaluation. This is not about abstract mechanics for their own sake; it is about ensuring real value for money at the clinic and district levels.

For real progress to occur, we need to be honest and address challenging issues. There is an inherent tension between a result-based approach and the drive to reduce conditionality. What is critical is that we learn from experiences and base our decisions on the evidence of what works and what does not. This includes a clear acceptance that one size does not fit all. Ultimately, mutual accountability means all of us being accountable for achieving results for people in countries.

Notes

- 1 Domestic resources represented only 3 per cent of all budgetary resources in 2007 and 2008, that is to say, less than 1 per cent of GDP.
- 2 From the 2009 ECOSOC high-level segment, 9 July 2009.
- 3 Ibid.
- 4 MDGs 4, 5, 6 and MDG1 on malnutrition
- 5 This is about 8 per cent now, from 5.3 per cent in the early 1980s.
- 6 Catalytic initiative to save a million lives, Global Campaign for MDGs 4-5, Providing For Health (P4H), International Health Partnership, High-level Task Force for Innovative Financing for Health Systems
- 7 In 2002-2006, 41 per cent of all health ODA focused on technical cooperation, which includes technical assistance and training activities. Source: "Effective aid – better health" WHO-World Bank and OECD publication, 2008
- 8 IHP+: International Health Partnership.
- 9 From the 2009 ECOSOC high-level segment, 9 July 2009.
- 10 Ibid.
- 11 United Nations Millennium Declaration, UN A/res/55/2, 10/09/200.
- 12 Count down to 2015 – Tracking progress in maternal, newborn and child survival; The 2008 Report.
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- 15 2008 Survey on Monitoring the Paris Declaration-Effective Aid by 2010? What it will take, Vol 1 Overview: 3rd High-level Forum on Aid Effectiveness, 2-4 Sept., 2008, Accra, Ghana.
- 16 Francis M. Mwegu. Wolfensohn Center for Development working paper n.8: A case study of aid effectiveness in Kenya: Volatility and fragmentation of foreign aid, with a focus on health-wprking paper The Brookings Institution, January 2009
- 17 Timothy Powell-Jackson, Josephine Borghi, Dirk H. Mueller, Edith Patouillard, Anne Mills Countdown to 2015: Tracking donor assistance to maternal, newborn, and child health Lancet 2006; 368:1077-87
- 18 Jennifer Kates, Eric Lief, Jonathan Pearson: Donor Funding for health in low and middle Income Countries, 2001-2006: The Henry Kaiser Family Foundation, July 2008
- 19 Accra Agenda for Action: Third High-level Forum on Aid Effectiveness, 2-4 September, 2008, Accra, Ghana
- 20 From the 2009 ECOSOC high-level segment, 9 July 2009.

Chapter 7

AFRICA AND THE LEAST DEVELOPED COUNTRIES: PARTNERSHIPS AND HEALTH

Overview

Africa and the least developed countries (LDCs) are still far from meeting the Millennium Development Goals on improving maternal health, reducing child mortality and combating infectious diseases. What is this slow progress attributed to? How should the human resource crisis be handled? How has the global economic downturn impacted the health agenda for Africa and the LDCs? Such questions were addressed at the Special Event on Africa and the Least Developed Countries, which was co-chaired by the President of ECOSOC, Ambassador Sylvie Lucas, and Mr. Cheick Sidi Diarra, United Nations Under-Secretary-General, Special Adviser on Africa and High Representative for Least Developed Countries, Landlocked Developing Countries and Small Island Developing States.

Moderated by Dr. Daisy Mafubelu, Assistant Director-General of Family and Community Health of the World Health Organization, the panel heard an interesting mix of representatives: Ministers, high-level officials from intergovernmental organizations, non-governmental organizations and the private sector.

While Ms. Mafubelu highlighted the urgent need to strengthen the health sectors, to address access gaps and handle the human resources crisis, Mr. Michel Kazatchkine, Executive Director of the Global Fund to Fight against HIV/AIDS, Tuberculosis and Malaria, warned against the risk of downturns in donors' commitments that would unravel progress made over the last three years. He advocated for continued large-scale interventions through the power of partnerships between multilateral organizations, the private sector and civil society.

Mr. Ponnem Dalalay, Minister of Health of Laos, and Dr. George Spia-Adjah Yankey, Minister of Health of Ghana brought the governmental perspective in the discussions. Minister Dalalay presented the public health policy implemented in Laos, which stimulates the participation of the population in these efforts and builds on the links between health interventions, other development dimensions and poverty reduction efforts. Minister Spia-Adjah Yankey made a strong call for increased access by Africa and the developing world to medical technologies. Special efforts should be made by the international community to facilitate such access without which considerable barriers to the improvement of the health situation will remain, thereby limiting development perspectives at large, given the huge cost of diseases, such as malaria, to these societies.

Mr. Klaus Leisinger, President and Executive Director of the Novartis Foundation for Sustainable Development, and Mr. Mike Boyd, Acting Director-General of the International Federation of Pharmaceutical Manufacturers, expressed the views of private sector organizations that are involved in helping poor countries improve their health sector. To boost private sector involvement, Mr. Leisinger stressed the need to learn

from existing best practices and to ensure well-established lines of responsibilities among the various actors involved. Mr. Boyd focused on the “quiet transformation” that has taken place over the last ten years with the involvement of the research-based pharmaceutical industry in improving healthcare in Africa, including increased Research and Development (R and D) efforts to tackle neglected tropical diseases in the continent.

Dr. Francis Omaswa, Executive Director of the African Centre for Global Health and Social Transformation, brought the perspective of an African non-governmental organization that fights against the current state of affairs. Dr. Omaswa highlighted the relevance of wide-scale advocacy campaigns to reject widespread ill health and premature death and to increase the leadership and stewardship role of governments. Increasing the number of skilled health professionals in Africa and elaborating financial instruments that maintain integrated delivery of personal care and public health were also recommended.

Africa, the Least Developed Countries, and the Millennium Development Goals¹

By Mr. Cheick Sidi Diarra, United Nations Under-Secretary-General
Special Adviser on Africa and High Representative for Least Developed
Countries, Landlocked Developing Countries and Small Island Developing
Countries

As this was the first time that a special session was devoted to Africa and the LDCs in the context of the ECOSOC Annual Ministerial Review (AMR) meeting, special gratitude was expressed to President Sylvie Lucas for taking this initiative.

The pressing needs and challenges of the poorest and most vulnerable countries in achieving the health-related MDGs and beyond are well known. It was for this reason that this particular AMR holds such significance.

There can be no discussion on global public health without a candid discussion on the state of health care in Africa and the LDCs.

Despite steady progress and extraordinary attempts at coordination across the international community, without laser-like focus on the health needs of the poorest countries, achieving the broader MDGs will remain elusive.

A number of strategic areas should be taken into account: strengthening health systems; attention to critical access gaps; the crisis in the health workforce; and the imperative of multi-stakeholder partnerships.

The latter is, of course, particularly pertinent in the context of the renewed multi-stakeholder outreach of the United Nations Economic and Social Council.

The following key issues deserve to be highlighted.

First, there has been an extraordinary convergence within the United Nations system on the need to focus on strengthening health systems. This vision has been embraced by other partners, such as the Gates Foundation, the Global Fund and the GAVI Alliance.

Second, the problems of access to healthcare in the poorest countries must be viewed through the lens of extreme poverty. There will be no open access to universal health care without access to clean water, sanitation, basic education and socio-economic empowerment for women. Therefore, there must be concerted efforts to implement national development strategies on all the MDGs.

Third, we must address the human resource crisis head on. The WHO has estimated the shortfall of health workers in Africa as exceeding 1.5 million people. This does not even take into account the problem of migration of nurses and doctors to richer countries.

Last, we must strengthen partnerships in global public health. The past few years have seen an increase in public private partnerships in this field. But there should be a greater focus on the needs of Africa and the LDCs.

Likewise, the commitments made by the major donors on health-related MDGs must be honoured despite the global economic downturn.

While the global response to HIV-AIDS, malaria, and TB should continue, we should not lose sight of the chronic non-communicable diseases and the diseases of climate change, which will increase the burden on healthcare systems in Africa and LDCs.

In closing, it is imperative to have a holistic view of healthcare as an enabler of socio-economic progress. ECOSOC is in a unique position to act as a catalyst at the ministerial level in promoting the implementation of health-related MDGs.

Technology in the Developing World²

By H.E. Dr. George Sipa-Adjah Yankey,
Minister of Health
Ghana

It is becoming increasingly clear that for Africa and the rest of the developing world to achieve the MDGs, we must make strategic use of science and technology to address the challenges of poverty, hunger and diseases in our parts of the world.

For us in Africa and the rest of the developing world, technology may mean less sophistication in the application of knowledge to solve our problems and fulfill our needs using skills, processes, techniques and tools that can be acquired within our resources.

Technology is the application of knowledge to meet human needs. Knowledge here includes both embodied and disembodied software or hardware. Almost invariably, it is the application of the two which best meets the needs of mankind. Needs in this context include basic needs, namely: food, health, education, shelter and clothing. Technology becomes relevant when it is able to meet these needs.

Advances in technological development cover a wide gamut of disciplines, including aviation and transportation, communication, construction, education, and health, among others, and continue to impact almost all spheres of human activities. Our focus in the health sector is how technology can enhance care delivery.

The past several decades have witnessed histrionic advancement in medical technology. We have witnessed the invention of both the small and the big, and the basic and the sophisticated. We have witnessed the invention of the electronic blood pressure monitor, rapid diagnostic kits for malaria, monitoring equipments for diabetes, on the one hand, and huge machines such as the CT Scan and the MIR, on the other hand. We have also seen the development of powerful and efficacious drugs for both old and new diseases, and beneficiary of wealth of new medical knowledge.

All these can be rightly considered as advances in medical technology. The question is: have these developments enhanced the quality of health care delivery to all and, if not, how can these be applied to support health care delivery to mankind?

It can be argued that these advances in health care have, on the whole, been beneficial to the citizens of the advanced countries. In these countries, there exist basic infrastructures and a financial architecture to enable the majority of citizens to access them and benefit from them.

It is not sure whether the same can be said for countries in Africa and LDCs. Nevertheless, there is hope for these countries, provided they are able to appreciate the relevance of the simple and basic technologies currently available and to situate them within the context of their health policies and programmes. For example, a country which puts premium on preventive care can reduce the incidence of malaria by encouraging the

mass use of Insecticide-Treated Nets (ITNs), insecticide curtains, encourage Indoor Residual Spraying (IRS), and well-targeted vector control programmes.

It is unfortunate that, even with these advances, many children continue to die of vaccine-preventable diseases, malaria and diseases that are easily treatable. Mothers continue to die through childbirth and diseases that have long been eradicated in some parts of the world.

Obviously, we are struggling to meet the MDGs not because we do not have the solutions to our health problems, but because we lack the resources to apply the tested and well-rehearsed interventions where it is needed in a sustained manner. In almost all instances, our inability to acquire and deploy the needed technology remains a formidable barrier.

The challenges facing LDCs are known. Indeed, this is a well-researched area. We have to fight a huge burden of diseases and other health challenges with meager resources. While the presence of these diseases constitutes a drain on our resources, we have no option but to spend more on their control. In a recent study conducted in Ghana, it was observed that malaria alone costs us over \$732 million every year. This is the burden of one disease on one developing country in Africa.

The development of our health infrastructure has lagged behind, as a result of continuing poor investments in the health sector. Our inability to invest more in the health sector stems out of many factors which, unfortunately, have been aggravated by the global economic recession. Simply put, many communities are without basic health services and this contributes significantly to our overall ability to meet the MDGs.

Matching Health Outcomes with Development Needs³

By H.E. Mr. Ponmek Dalaloy
Minister of Health
Lao People's Democratic Republic

In a globalized world, marked by post-modernity and post-industrialization, the “integrated health and environment set” has become the ultimate goal for sustainable development. Global health initiatives should, therefore, benefit from appropriate mechanisms that enable them to lead to tangible results on the ground. In developing countries, the weakness of health infrastructures is a major obstacle to this objective.

Developing human resources for health and promoting the active participation of the people are key to strengthen national health systems. It is, therefore, important to ensure that global health programmes and national health systems are closely coordinated, in order to have the expected impact on the ground.

Through its cooperation with the Global Fund, the Lao Democratic People's Republic has successfully reached agreed targets and effectively built its capacities. The reasons and lessons learnt from that success are the following. First, the Global Fund has clear scope, precise targets, comprehensive goals, objectives, appropriate strategies, measures and implementation arrangements or mechanisms and styles, which have guided the country in implementing activities. Second, the country has strived to actively promote the principles of ownership, harmonization, alignment, result-based, transparency, efficiency and accountability. However, some difficulties have limited the integration of global health initiatives to the health system of the country, such as differences in criteria used or in the composition of institutional mechanisms.

Brief country presentation

The Lao PDR is a small country (236 800 km²), with a population of 5.6 million but comprised of 49 ethnic groups with different levels of development, languages, customs and ways of life. Close to 80 per cent of the population live in rural, mountainous and remote areas, many of whom rely on slash burn cultivations.

After a long period of war, poverty remains widespread. The national market is too limited to stimulate production. Access to education and health care remains difficult for many citizens. Faced with health catastrophes, people often react with superstition and taboos. Comprehensive health literacy activities are, therefore, needed. Old challenges are communicable diseases, and high infant and maternal mortalities. New challenges are emerging and reemerging diseases and non-communicable diseases are linked to development and change of lifestyle.

Scaling up health literacy programmes through increased people's participation

Increasing health literacy requires decentralizing information, education and communication activities to the grassroot level, in order to promote ownership by the population and to make changes from the bottom up.

To scale up the process, the Government has implemented integrated rural development policies including: agriculture; communication; education; and health as pillars for development. These policies have been implemented in healthy model villages, with a focus on the mother and child. Activities cover all the components of primary health care programmes such as:

- providing village drugs kits to two or three village volunteers so that they can give basic care to the members of the still nomadic villages;
- replacing the traditional birth attendants by skilled birth attendants (SBA);
- extending the coverage of family planning through the provision of antenatal care;
- ensuring the safety of the mother and the new born when breast feeding;
- extending immunization;
- encouraging an integrated management of childhood illnesses; and
- reducing malnutrition through increased agricultural productivity and efficiency, in connection with natural disasters or epidemics preparedness efforts.

People's participation is crucial to the success of development policies. To that end, it has been decided to decentralize hospital structures (CHIPU)⁴ to these healthy model villages.

Health literacy activities include three major "clean elements", namely drinking boiled water or other kinds of safe water; eating cooked foods; and using appropriate latrines. The content of this policy can be modified and enriched to respond to concrete needs of communities at specific periods. This can include targeting other topics related to the health environment or determinants, resolving in a rational way wasted waters, finding appropriate means for eliminating solid waste, sleeping in impregnated bed nets for preventing malaria and dengue fever, etc. These activities are not the monopoly of the health sector; they are the tasks and duties of all sectors: schools, from kindergarten to high school, mass organizations such as the Lao women union and youth organizations, the monks, opinion makers and the media.

For the Lao People's Democratic Republic, MDG 4 can be reached as expected, while MDG 5 remains a serious challenge, as training skilled birth attendants (nurses, midwives, family medical assistants, and family doctors) requires long-term efforts. Participatory efforts to increase health literacy can lead to additional results in related development fields, such as access to safe drinking water and the reduction of malnutrition. An effective social know-how of explanation and mobilization is needed to effectively move forward on this matter.

The need to strengthen human resources for health through a top down approach

The grassroot level in the Lao health system is constituted by the health village committee formed by the village chief, the team of village health volunteers or workers, traditional birth attendants and mass organization representatives, including women, youth and religious representatives. In bigger villages, health prevention and promotion activities are implemented by health centres with more qualified staff.

Planning and financing are carried out at the district level, with three major areas of action: health promotion, curative action and administration. Hospitals play a crucial role as the fundamental working team of the district.

The provinces deal with strategic action, while the central level plays a policy and normative role.

The current health system is satisfactory in its organization and structure, but its staffing is not adapted. In this transitional period, there is a continued lack of medical doctors, family medical assistants and skilled birth attendants, in particular midwives or nurses-midwives. More than 80 per cent of the staff at the village level and in health centres has insufficient qualifications. The CHIPU is only at its initial stage of creation and is still growing up.

Technical and financial support are, therefore, needed. The Lao DPR is committed to taking an active part in the development of new global health initiatives that will help to further develop the country's health system.

Progress and Distribution: Suggestions for Improving Health in Africa⁵

By Mr. Klaus M. Leisinger
President and Executive Director
Novartis Foundation for Sustainable Development

The facts on morbidity and mortality of the vulnerable populations in Africa and the LDCs are well known to everybody who cares to know. We are also aware of the remarkable progress that has been made in the past decade in improving the health of poor people in low- and middle income countries. Responsible for the success achieved is a coalition of motivated actors from the international community, multilateral organizations, governments, NGOs and the private sector. From the progress we have made, we know what it takes in resources, skills and political will to get things done.

However, progress achieved has not been equally distributed among the countries; neither has it been fairly distributed within the countries. Different qualities of governance, different priorities in the allocation of scarce resources and differences in the cost-effectiveness of the approaches chosen have led to significant differences in the health development performance for the world's poor. Unfortunately, many rich countries have not lived up to the commitments they made - and there are leaders and laggards within the private sector and civil society.

In view of the negative impact of the current global financial and economic crisis and, given the fact that the world population will grow by another 3 billion people in the next 50 years, there is a lot of reason for concern that we will not make the progress that could be achieved and would be desirable.

In this situation it is very important to:

- learn from existing best practices and apply the lessons learned wherever we work;
- be aware that there is a distribution of responsibility and division of duty in well - organized societies and to make sure that we are not trying to push one actor's responsibility to another actor's responsibility portfolio;
- use all possibilities for cooperation in good faith, in order to take advantage of the feasible synergies and the plurality of resources, skills, and experience that we can bring together.

The private sector is expected to be part of the solution and not part of the problem. This means, first of all, to compete with integrity and to be profitable, socially responsible and environmentally sustainable in their core areas of competence.

The pharmaceutical industry will have to be a credible and visible actor in the fight against poverty and for the achievement of the MDGs, especially the health-related ones. This means to be successful in research and development, in order to come up with innovative and better medicines and new vaccines that are so badly needed.

Enlightened companies will offer preferential pricing systems for the essential drugs needed in the fight against poverty diseases, and they will contribute with pro-bono research and give donations.

Enlightened nations and actors of civil society will give incentives to those companies that live up to societal expectations, offer and deliver solutions that can make a difference, in cooperation with other actors, in order to reach sustainable success.

The Quiet Transformation: Health, HIV/ AIDS and Other Diseases in Africa⁶

By Mr. Mike Boyd
Acting Director-General
International Federation of Pharmaceutical Manufacturers (IFPMA)

Lasting change is rarely sudden. Over the last decade or so, a quiet transformation has been going on, strengthening the links between the developed world and Africa, especially in the area of health.

Why this intensified focus on health in Africa? Perhaps because, if the health challenges there are greater, then so, too, are the opportunities because even modest improvements in African health will provide a significant boost to economic development.

The untold story of HIV/AIDS is the amount of working time lost each year to the disease in Africa; dealing with AIDS in Africa is both a humanitarian and an economic imperative. The same is true of malaria, which historically has been a major brake on economic development of the continent, and it remains so today - costing Africa's economy an estimated \$12 billion per year.

Part of the quiet transformation that has been going on is the growing involvement of the research-based pharmaceutical industry, represented at international level by the IFPMA, in improving African's health. All in all, our industry makes a very significant contribution to helping countries to achieve the health-related MDGs. From their inception in 2000 to end of 2007, our companies made available enough medical assistance to reach 1.75 billion people. Most of those people were in Africa, because that is where the bulk of our efforts are concentrated. To set this into perspective, the value of assistance to developing countries provided by our companies in 2005 amounted to \$1.5 billion - equivalent to 11 per cent of all health development aid provided that year by all governments of the Organization for Economic Cooperation and Development (OECD).

How do our companies help Africa? The Health Partnerships database on our internet site⁷ shows the industry programmes active in different countries: 23 in Burkina Faso; 19 in Ethiopia; 43 in Kenya; 28 in Mali; 41 in Uganda; and 25 in Zambia.

In Uganda, there are programmes in HIV, providing the latest antiretroviral medicines at preferential prices (more than 40 per cent of the 3 million people living with AIDS in the developing world now receive antiretroviral via our preferential price programmes), and also programmes to prevent mother to child transmission, to help treat children with AIDS and to teach African health workers to treat AIDS effectively.

There are also programmes to address malaria and other tropical diseases. Some of these programmes, such as the Mectizan Donation Program for River Blindness, are huge - reaching over 60 million people - and have been going on for many years (21 in the case of Mectizan).

Some tropical diseases have been characterized as “neglected diseases”, because there was little money made available and so industry was not interested. That situation has been quietly changing, as shown in our exhibition on the industry’s growing R and D effort for diseases of the developing world in the ECOSOC innovation fair. In 2005, our companies were working on 32 new medicine projects for the 10 main diseases of the developing world and; this year, the number has increased to 75.

Our companies are also aware that African countries’ health problems are not limited to infectious diseases. The fastest growing category of company health development programme is child and maternal health, followed by chronic diseases. In the last two years, our companies added more programmes to address these two health challenges than all other types of diseases combined.

Finally, we also run programmes to help strengthen primary health care and health infrastructure in Africa - in Uganda alone, there are five capacity-building programmes which are not focused on any particular disease. Capacity-building covers a wide range of activities, from teaching volunteers on how to advise tuberculosis patients to stick with their lengthy treatment, to providing clinical research fellowships to promising young African postgraduate researchers.

Matching Health Outcomes with Human Development in Africa and the Least Developed Countries⁸

By Dr. Francis Omaswa
Executive Director
African Centre for Global Health and Social Transformation (ACHEST)

Health is the highest ranked priority among the poor, as evidenced by the results of Participatory Poverty Assessment Studies (APPAS) in many countries, where it is most frequently cited by the poor themselves as the cause and consequence of their poverty. Sometimes, a healthy body is the only asset that a young man or woman may possess. Freeing people from the humiliations and indignities brought about by ill health and unmitigated disability, freeing the time and energy lost through illness, caring for the sick and burying the dead is what human development is about. Such time can be used for economic productivity, educational opportunity, recreation and social activity that dignify the human condition and bond society and to make life truly worth living.

The disease burden in Africa is incredibly high, both chronic and acute. For many years, as a member of a group of surgeons, ASEA, who traveled to remote hospitals every three months in one of the eight countries in East, Central and Southern Africa to hold surgical camps. We were always overwhelmed by hundreds and thousands of patients, some blind from cataract, others with bumps and lumps, women with fistula and huge uterine fibroids, young children with grotesque neglected birth defects - all so depressing and upsetting. Our people are living like animals in the wild! Among these populations, premature death is accepted as normal, designated as fate or even as an act of God. At the frequent funerals, we make speeches; for a young woman who died in child birth, we say "well, it was her day", for a child who died of malaria, we say "God gives and takes away. God has called him/her". Our very first step is to reject this. Every death should be regarded as a failure of the health system, the failure of those who are at the funeral. Collective actions should be taken to prevent a recurrence of similar deaths. This is what happens in better organized societies. God does not call Japanese children until they reach the age of 85. Does God call Africans more than Japanese? The answer is no; Japanese just take better care of their people.

Africa, like the rest of the world, must also take this route. I have seen an Africa that was full of hope and promise just before and after independence, followed by a demoralized Africa in decline and now an Africa with a new hope rising from the dictatorships, HIV/AIDS, seeing economic growth in a globalized world, clamoring for social justice, bringing in so many new players into global health, replete with knowledge and technology. Africa must grasp this opportunity.

Here are my suggestions for critical interventions, among others, that hold strong potential at this point in time for better health outcomes and human development in Africa:

- we need to launch a vigorous advocacy campaign to reject rampant ill health and premature death and in support of strong and transformed pro poor health systems at the same level that we fought for a global response to HIV/AIDS.
- Government leadership and stewardship are critical in our journey. Without strong governments in Africa, the change that we desire will not come. However, governments also need to be facilitated and supported to be strong stewards. We need to recruit heads of state and governments into this movement. We need to support and strengthen leadership and governance capacity of ministers of health and build institutions to support them in each country. The WHO Commission on Social Determinants of Health stresses the need to include health in all policies but assigns leadership for this to the minister of health. Ministers of health need to be supported to be champions and stewards of all health resources in their countries. With the support of outside partners, ACHEST has been interviewing current and former ministers of health, leaders who work closely with them in countries, the United Nations system and other multilateral actors. While a full report will be published in a few months, preliminary findings indicate the desire of Ministers of Health to develop personal skills and institutional capacity around them for knowledge gathering, analysis and use.
- the health workforce needs very urgent attention in African countries. We need a critical mass of appropriately skilled cadres of health professionals in each and every country who are motivated to serve in rural areas. They also need to be facilitated to meet together regularly, holding each other as peers to account, governments to account and providing technical and political support to governments while engaging in a dialogue with their societies as change agents. We need to cultivate a “can do” attitude among these professionals in countries. Flying in technical assistance to Africa is not the answer, as there is sufficient raw material locally that can be provided with the needed skills. In March 2008, GHWA convened the first global forum on human resources for health and adopted tools to move forward in this important area of work. Primary health care principles should involve the active participation of people as the owners and the beneficiaries of health programmes instead of waiting for others to do things for them.
- lastly, financing instruments for channeling money to health programmes should support integrated delivery of both personal care and public health, and across-the-board capacity for planning, implementation, monitoring and evaluation. Countries should find innovative ways to raise local funds for priority health programmes.

Notes

- 1 From the 2009 ECOSOC high-level segment, 8 July 2009.
- 2 Ibid.
- 3 Ibid.
- 4 CHIPU stands for “Complex-Hospitalo-Instituto-Proyecto-Universitaire”

- 5 From the 2009 ECOSOC high-level segment, 8 July 2009.
- 6 Ibid.
- 7 See <http://www.ifpma.org>
- 8 From the 2009 ECOSOC high-level segment, 8 July 2009.

Chapter 8

THE 2009 ECOSOC INNOVATION FAIR

Overview

To showcase innovations in global public health and to mobilize a wide range of stakeholders in support of the work of the Economic and Social Council, the United Nations organized an Innovation Fair during the Council's high-level segment. The fair ran parallel to the Annual Ministerial Review (AMR) organized by the Council devoted to global public health".

Over 30 entities (UN entities, other international organizations, non-governmental organizations-NGOs and private sector entities) showcased innovative projects at the Fair, which was launched by the United Nations Secretary-General on 3 July 2009. The Fair contributed to the objectives of the 2009 Annual Ministerial Review, in particular by:

1. Promoting broad multi-stakeholder engagement in the work of ECOSOC;
2. Sharing innovative solutions and best practices in the area of global public health;
3. Demonstrating the strong links between public health and the other International Agreed Development Goals (IADGs) / Millennium Development Goals (MDGs);
4. Encouraging interaction among participants in the Fair and Member States, which could possibly lead to the launching of initiatives.

The Innovation Fair was organized around three themes: (i) ICT tools for health; (ii) Innovative partnerships for health and development; and (iii) Improved access to health for vulnerable populations.

This chapter contains a brief presentation of the projects showcased at the Innovation Fair. For each theme, the projects are listed accordingly to the category of the main actors responsible for them (UN system and other international organizations, NGOs, private sector). More information on these projects can be found on the Council's website at: <http://esango.un.org/innovationfair/>

A. ICT Tools for Health

UN system and other international organizations

1. Wireless Broadband Partnership

By the International Telecommunication Union (ITU)

Connecting the unconnected remains a challenge. While mobile connectivity has improved over the world, high speed broadband connectivity necessary for the transmission of large amounts of data and high-quality images required for key e-health applications, is either not available or prohibitively expensive in many developing and least developed countries. Traditional business models, especially in rural and remote areas, often do not support the needed investment. In addition, insufficient local content is available and too few people have training in the required technologies.

To overcome these challenges, new approaches are needed, including innovative public-private partnerships, involving committed stakeholders working together towards a common goal. To this end, the International Telecommunication Union (ITU) is bringing together partners from government, industry, financial institutions and other stakeholders as part of a shared effort to connect the world. The objective of the Connect the World initiative is to mobilize the human, financial and technical resources required to bridge major gaps in ICT/telecommunication infrastructure thus, supporting affordable connectivity and applications, such as telemedicine and e-health services, to stimulate economic growth, employment and development in all regions.

The ITU Wireless Broadband Partnership will mobilize key stakeholders to finance, plan, build, operate and maintain wireless broadband infrastructure within beneficiary countries, with particular attention to underserved populations in rural and remote areas.

ITU will work with governments and other partners to identify specific areas to be covered within each participating country and determine and mobilize the resources required for implementation.

ITU is the leading United Nations agency for information and communication technology (ICT) issues and the global focal point for governments and the private sector in developing networks and services.

2. Innovation: New Technology - New Partnerships - Going to Scale

By the United Nations Children's Fund (UNICEF)

A concept of health system and monitoring facility was presented by UNICEF at the 2009 Innovation Fair. Key items and products with innovations ranging from auto-disable (self-blocking) syringes, Plumpy'nut (for the use of therapeutic food used to treat severe malnutrition), and the anti-shock garment for postpartum haemorrhage. In addition, more "technological" endeavours like mobile phone triaging and portable field analysis units from an award-winning open source project were showcased. A national / aggregate monitoring facility, showing results from real time data gathering, health statistics and trend mapping was also presented. Particular emphasis was given to the work done by partners in private sector, academia and development around initiatives that can be taken at the global scale. UNICEF's participation at the Innovation Fair aimed to provide an overview of innovative partnership work; and how integrating and partnering in creative ways allow health workers at all levels to work more efficiently. Moreover, it allowed strategic users in information systems, such as ministers of health, to see data quickly and accurately at national levels and respond appropriately where needed.

3. Telemedicine in Ethiopia

By the International Telecommunication Union (ITU)

Ethiopia is a country with a population of about 75 million inhabitants, of which, about 85 per cent live in rural areas. The present health care facilities and manpower availability in the sector remain insufficient. Over one-third of the population lacks access to primary health care service and two-thirds lack access to primary hospitals. Moreover, Ethiopia's inadequate transportation infrastructure makes it difficult to provide health care services in remote rural areas.

The project Telemedicine in Ethiopia aims to ensure access to affordable and clinically acceptable primary care telemedicine for the underserved rural population. The project was pioneered in 1998 by the International Telecommunication Union (ITU), working in close collaboration with Ethiopian Telecommunication and the United Nations Economic Commission for Africa (UNECA). In later years, the project has been led by the National Telemedicine Coordinating Committee. This project is part of UNECA's National Information and Communication Infrastructure (NICI) initiative, which aims at developing policies, plans and sectoral e-strategies on e-government, e-health, and e-education.

4. e-Health in Nepal

By the International Telecommunication Union (ITU)

Access to health care is of great importance, especially for remote areas where there are a few or no health workers available to provide quality health care. Nepal is a mountainous country with a population of about 24 million, of which a large percentage lives in mountain villages accessible only by foot. As a result of the lack of roads and industrial development in such communities, there are very few facilities that provide health services to the rural population.

e-Health in Nepal is an initiative undertaken by an NGO, with the support of the ITU and the Ministries of Information and Communication and Health and Population of Nepal. The project aims to set up telemedicine centres in rural villages and connect them to main hospitals in the region to provide health services electronically.

The introduction of e-health applications will facilitate the provision of health care services, health surveillance, health literature, and health education in a cost-effective manner through the secure use of ICTs. ITU's role in this project is to provide equipment and conduct training sessions to build human capacity as necessary.

Non-Governmental Organizations

5. Infopoverty Programme for Health related MDGs¹

By the Observatory for Cultural and Audiovisual Communication (OCCAM)

Infopoverty is a programme coordinated by the Observatory for Cultural and Audiovisual Communication (OCCAM) created by UNESCO in 1997 that involves more than 100 international institutions and national entities participating since 2001 in the annual Infopoverty World Conference, promoted by the European Parliament under the aegis of the United Nations, and under the High Patronage of the President of the Italian Republic and the Patronage of the Presidency of the Italian Council of Ministers.

Infopoverty is a common platform aimed at fighting poverty through an innovative use of information and communication technologies (ICT) regarded as tools able to provide broadband wireless services, such as telemedicine, e-government, e-learning, to support development in the most disadvantaged communities. The aim of the Infopoverty Programme is to ensure that the digital revolution becomes an instrument for sustainable development that gives to communities the possibility to promote themselves as socio-economically valid subjects.

6. Réseau en Afrique Francophone pour la Télémédecine (RAFT)

Continuing education of health care professionals and access to specialized advice are keys for the quality and efficiency of a health system. In developing countries, these activities are usually limited to capitals and local professionals that do not have access to such opportunities, or even to didactic material adapted to their needs. This limits the interest of such professionals to remain active in rural areas, where they are most needed to implement effective strategies for prevention and first-line healthcare.

In order to address these needs, the Geneva University Hospitals have developed a telemedicine network in Africa (the RAFT, Réseau en Afrique Francophone pour la Télémédecine), first in Mali, then in Mauritania, Morocco, Cameroon, and, since 2004, in Burkina-Faso, Senegal, Tunisia, Ivory Coast, Madagascar, Niger, Burundi, Congo-Brazzaville, Algeria, Chad, and Benin.

The core activity of the RAFT is the webcasting of interactive courses targeted to physicians and other care professionals, the topics being proposed by the partners of the network. Courses are webcast every week, freely available, and followed by hundreds of professionals who can interact directly with the teacher. Seventy per cent of these courses are now produced and webcast by experts in Africa. A bandwidth of 30 kbits/second, the speed of an analog modem, is sufficient and enables the participation from remote hospitals or even cybercafés.

Other activities of the RAFT network include teleconsultations, tele-echography, and collaborative development of educational on-line material.

7. Telepathology in Zambia

By Patologi Oltre Frontiera

Patologi Oltre Frontiera aims to (1) build new surgical pathology laboratories and to form new technicians and new pathologists in developing countries; and to (2) use some new technologies (internet with satellite connection) to formulate a diagnosis on line and to form the local personnel from remote.

The experiment was realized in Zambia between 2004 and 2008.

Private Sector

8. Toward a specific e-Health data tool - e-Health Cartography²

By CATEL

CATEL is an association created in October 1997. It has become a network of more than 9000 contacts concerned by telemedicine (practitioners, firms, associations, institutions), and 500 active members. CATEL aims to contribute to the development of telemedicine by informing, organizing meetings and consulting.

CATEL, the unique multidisciplinary French structure for telemedicine and eHealth, is the core coordinator to establish the larger telemedicine and e-Health “cartography”, to list all the actions, articles, projects and application all over the world.

B. Innovative Partnerships for Health and Development

United Nations system and other international organizations

9. Advance Market Commitment (AMC): Preventing Pneumococcal Diseases

By GAVI Alliance

The Advance Market Commitment (AMC) is a new approach to public health funding designed to stimulate the development and manufacture of vaccines for developing countries.

Donors commit money to guarantee the price of vaccines once they have been developed thus, creating the potential for a viable future market. Decisions regarding which diseases to target, criteria for effectiveness, price and long-term availability are made in advance. The donor commitments provide vaccine manufacturers with the incentive they need to invest the considerable sums required to conduct research, train staff and build manufacturing facilities. In exchange, participating companies must guarantee to supply their vaccine for a period of 10 years at a pre-agreed low price (tail price).

Developing country governments are, therefore, able to budget and plan for immunization programmes, knowing that vaccines will be available in sufficient quantity, at a price they can afford, for the long term.

10. The International Finance Facility for Immunization (IFFIm)

By GAVI Alliance

In the developed world, protection from disease through immunization is taken for granted. But every year in poorer countries, some 24 million children miss out on vaccinations against the most common diseases, making them vulnerable to sickness, disability and death. Every year, approximately 2.3 million children die from easily-preventable diseases such as diphtheria, pneumonia, diarrhea and yellow fever -- a massive and inexcusable loss of human potential.

One of the main reasons for this global failure is a lack of predictable, long-term funding that allows developing countries to plan and implement programmes to protect and improve their children's health.

The IFFIm exists to rapidly accelerate the availability and predictability of funds for immunization. The funds raised by IFFIm are used by the GAVI Alliance, a public-private partnership which aims to reduce the number of vaccine-preventable deaths and illness among children under five. IFFIm raises finance by issuing bonds in the capital markets and so converts the long-term government pledges into immediately available cash resources. The long-term government pledges will be used to repay the IFFIm bonds.

11. The Medicines Patent Pool Initiative

By UNITAID

UNITAID's mission is to contribute to scaling up access to the treatment for HIV/AIDS, malaria and tuberculosis, primarily for people in low-income countries, by leveraging price reductions for quality diagnostics and medicines and accelerating the pace at which these are made available.

Through a collective management structure for medicines patents, known as a patent pool, UNITAID seeks to improve access to patents and foster the development and production of life-saving, more affordable, and more suitable medicines. UNITAID was given the go-ahead to create a patent pool on 3 July 2008, when its Executive Board approved the plan, in principle. The next steps undertaken by UNITAID will be to develop an operational plan for the creation of the patent pool.

The medicines patent pool will be focused on HIV medicines initially, concentrating on those products that are needed but are not yet developed (such as second-line medicines and pediatric formulations) and on those existing products for which the number of suppliers is insufficient to create economies of scale. Once up and running, the pool could expand to serve other disease areas of need.

12. UNFPA's Developmental Approach: Reaching Common Ground by engaging Faith-Based Organizations as Agents of Change

By the United Nations Population Fund (UNFPA)

UNFPA regards culture as a critical component of development and religion as an important aspect of cultural landscape. Because of the prominent role that religion plays in so many communities around the world, religious leaders, faith-based organizations (FBOs) and faith-based service delivery networks often have the potential to be among the most influential agents of change. FBOs provide anywhere between 30-70 per cent of the health services in many parts of the developing world. From 2006-2008, UNFPA undertook a mapping of its partnerships with FBOs working on the MDGs and the ICPD Programme of Action. The resulting publication, entitled "Culture matters: A legacy of engaging faith-based organizations" outlined 100 UNFPA Country Offices, which partnered with over 75 different FBOs around the world.

Over the course of 2007 and 2008, UNFPA intensified efforts to consolidate these partnerships through several regional consultations in Africa, Asia-Pacific, the Arab States and Latin America and the Caribbean. In each of these, FBO partners were invited to openly reflect on their engagement with UNFPA on a range of issues, including maternal health, HIV and AIDS, women's empowerment, migration, and youth. The consultations resulted in several recommendations to enhance these partnerships for governments, the United Nations, and for their own faith-based colleagues.

Non-Governmental Organizations

13. Health Promotion and Global Partnerships: Women and Diabetes

By The Global Alliance for Women's Health (GAWH)

A cornerstone of GAWH's work has been to develop public/private partnerships that advance an understanding of all aspects of women's health throughout the life cycle, and to articulate the implications of this knowledge for public policy and development at the international and country levels. GAWH has developed partnerships with foundations, universities, and United Nations agencies, as well as a cross-section of international and national NGOs and private sector corporations, in order to present symposia, organize and facilitate caucuses and develop international networks at United Nations world meetings.

GAWH's participation at the 2009 Innovation Fair featured a cross-section of the alliances and partnerships that address women and diabetes, with particular focus on diabetes and pregnancy. For example, the World Diabetes Foundation (WDF) contributed materials to the display, including a film, entitled "Breaking the Chain," and an interactive map of their global diabetes projects. Results from a community-based study - Diabetes in Pregnancy Awareness and Prevention (DIPAP) study - conducted in rural India by Dr. V Seshiah to determine the prevalence of GDM in a community in India was also featured. There were posters displaying information from the Hyperglycemia and Adverse Pregnancy Outcome (HAPO) study, as well as posters on GAWH's initiatives at the United Nations: the Friends of the United Nations Diabetes Resolution and the Council on Gender-based Health.

GAWH used the information presented at the Innovation Fair to raise the level of interest in diabetes and women's health and to give attendees with information on pilot projects that provide diabetes screening and treatment programmes.

14. Medicines for Malaria Venture (MMV)

For too many years, efforts to prevent and treat malaria have been under funded, under researched and poorly coordinated. Tools for malaria control have failed to keep up with the evolution of the parasite. Today, only the new class of Artemisinin-based Combination Therapies (ACTs) remains broadly effective against the most virulent strains of malaria. However, as with all antimalarials, ACTs also face the ever-present risk of emerging resistance. The need for new antimalarial drugs is clear.

MMV's *modus operandi* brings together public, private and philanthropic sector partners to fund and manage the discovery, development and delivery of new antimalarials. Over the past nine years, MMV has built and developed the largest-ever managed portfolio of antimalarial drug research and development projects; currently with close to 50 projects, including one approved ACT, a further two in regulatory submission at stringent regulatory authorities and six in human clinical trials.

15. The LEAP Platform (Leishmaniasis in East Africa Platform) for Leishmaniasis

By DNDi Drugs for Neglected Diseases Initiative

The LEAP Platform (Leishmaniasis in East Africa Platform) is a regional clinical research network that brings together experts from leishmaniasis-endemic countries in East Africa. Founded in Khartoum, Sudan, in 2003, by the non-profit Research and Development organization Drugs for neglected Diseases Initiative (DNDI), the LEAP Platform incorporates partner institutions from across the spectrum of clinical research and disease control organizations working in leishmaniasis. Visceral leishmaniasis (VL) is the most severe form of tropical diseases, which are transmitted by the sandfly. VL is characterized by prolonged fever, enlarged spleen and liver, substantial weight loss,

progressive anaemia, and is complicated by co-infection with other infectious diseases, such as malaria, pneumonia, and HIV. Of the 200 million people in 62 countries who are threatened by VL, approximately 500,000 new cases and 60,000 deaths occur each year. VL is a fatal disease that kills almost all untreated patients, mostly affecting patients who live in areas where access to health care is minimal and is a disease embedded in poverty and neglect. If the number of treatments has increased in the past decade, there are numerous drawbacks for each of them, such as difficulty to administer, length of treatment, toxicity, cost and increasing resistance

Developing drugs is a difficult process, especially when clinical trials are carried out in remote settings. The aim is to strengthen clinical research capacity, which is lacking in part due to the remoteness and the geographical spread of the patients (most of whom live in the most impoverished regions of Africa). The LEAP Platform gathers a group of scientists and institutions working on developing clinical trial capacity to bring new visceral leishmaniasis treatments to patients. It currently involves partner institutions in four countries: in Kenya - the Kenya Medical Research Institute (KEMRI) and the Ministry of Health; in Ethiopia - Addis Ababa University (AAU), the Drug Administration and Control Authority (DACA), and the Ministry of Health; in Sudan - the University of Khartoum, and the Federal Ministry of Health; and in Uganda - Makerere University and the Ministry of Health.

Private Sector

16. BD/FIND Collaboration: TB Liquid Culture³

By Becton Dickinson and Company (BD) and the Foundation for Innovative New Diagnostics (FIND)

Through this landmark initiative, BD, in partnership with FIND, is leading the effort to improve access to diagnostics for tuberculosis (TB) in the developing world. BD's liquid culture system dramatically improves the speed and accuracy of TB diagnosis, which helps reduce the spread and mortality rate of TB.

Through studies in South Africa, Zambia, Brazil, Nepal, Russia, Philippines, Kenya, India and Uzbekistan, BD demonstrated the effectiveness of advanced liquid culture technology. Notably, the partnership focused on patients co-infected with TB and HIV, a particularly vulnerable population. The findings of these studies contributed to the scientific body of knowledge on the efficacy and feasibility of implementing this technology in high-burden TB settings. This in turn led the World Health Organization to endorse the liquid culture method as the standard for TB diagnosis and patient management.

17. Case Studies for Global Health

By Global Health Progress

The Bill and Melinda Gates Foundation, World Health Organization-based Special Programme for Research and Training in Tropical Diseases (TDR), International AIDS Vaccine Initiative (IAVI), Association of University Technology Managers (AUTM) and Global Health Progress (GHP) have joined together to prepare a set of multi-sector case studies to identify ways in which key stakeholders are addressing global health concerns. These studies will describe existing or planned collaborative relationships, projects and transactions with the aim of sharing lessons learned with the wider global health community.

The aim of this initiative is to involve a broad range of stakeholders with real world experience in contributing case studies that would provide others with information on current practices and insight on “lessons learned” (both positive and negative) in the course of conducting activities relating to global health matters. The case studies illustrate a broad range of efforts, including product discovery and development (drugs, vaccines, diagnostics, chemicals for vector control, crops, etc.), financing mechanisms, regulatory issues, and delivery efforts.

18. Partnerships to Increase Research and Development for Diseases of the Developing World

By the International Federation of Pharmaceutical Manufacturers (IFPMA)

Discovery and development of treatments and preventive technologies targeted at the so-called "Neglected Diseases" of the developing world have long posed vexing scientific and regulatory challenges. Since the beginning of this decade, the world's research and development (R and D)-based companies -- represented by the International Federation of Pharmaceutical Manufacturers and Associations -- have significantly stepped up pharmaceutical and vaccine research and development programmes directed at Diseases of the Developing World (DDW). This positive trend has been encouraged by broad use of partnership approaches, with *ad hoc* product development partnerships, bringing together private R&D-based pharmaceutical companies, universities and government research laboratories.

In addition to in-house projects supported by major R and D-based pharmaceutical and vaccine companies, member firms are increasingly undertaking R and D for DDW in external collaborations with a range of institutions that include: (i) Ad-hoc product development partnerships, focused on specific diseases or disease areas (including inter-company collaborations); (ii) Medical & Scientific Research Universities; (iii) Intergovernmental bodies such as the WHO/UNICEF/UNDP/World Bank Special Program for Research & Training in Tropical Diseases (TDR); (iv) National governments, including Public Research Laboratories; and (v) Philanthropic

organizations (that have made important contributions, especially through targeted funding)

19. Neglected Tropical Disease Control in Uganda

By Partnership for Disease Control Initiatives (PDCI)

PDCI is a coalition of NGOs, pharmaceutical companies, WHO, donors, and other partners collaborating on disease-specific drug donation programs for neglected tropical diseases (NTDs). PDCI provides a forum for stakeholders to share best practices, information, and experiences and to discuss tools and strategies to improve access to essential medicines for populations affected by NTDs. In Uganda, for example, drugs are being donated for mass chemotherapy by PDCI members and partners to control and/or eliminate six NTDs.

Country programs procure drugs by applying to WHO and/or a drug donation program. Applications are approved based on specific criteria that ensure the feasibility of safe administration and adequate financial support. Countries and NGO control programs working in co-endemic areas co-administer treatments for NTDs whenever possible resulting in cost-effective, streamlined interventions. The treatments are primarily distributed through the Community Directed Intervention strategy by Community Drug Distributors, which facilitates sustainability and builds capacity.

C. Access to Health Care for Vulnerable Populations

United Nations system and other international organizations

20. Community Based Management for Health: Adaptive Implementation in the Millennium Villages Project

By the United Nations Development Programme (UNDP), and the Earth Institute, Columbia University

Community-based management for health (CBMH) is the operational framework to enable tighter interconnections between clinics and the communities they serve in low-resource settings. Although various national policies exist that preclude uniformity in the package of primary care skills and services offered, CBMH focuses upon the optimal management, supervision and implementation of available resources. Through this process, human resources for health, such as community health workers, are developed from a management/operational perspective to tightly interlink communities with clinics while alleviating the inappropriate burden of preventative ailments in health centers. This requires well-developed and interlocking supervisory mechanisms to ensure that errors are corrected and services are optimally delivered.

Adaptive implementation is an approach that is predicated upon adapting “core” strategies to local resources and needs. Instead of implementing a static model and waiting to see if it leads to a desired outcome, the adaptive implementation approach begins by assembling a suite of best practices and then adapting them with data feedback to find a locally optimal approach. For example, regional policies may dictate that CHWs must be volunteers, paid as a group, paid individually or engage pay for performance. Each of these parameters requires a different approach to organizing support, skills and supervision to meet common goals. This approach uses light weight, high frequency operational research to improve service delivery and inform management decisions. In most scenarios, the desired outcome of lower mortality and morbidity is clear, while the sustainable implementation route is less so; adaptive implementation is an approach to bridge this gap.

21. Community Based Health and First Aid in Action for Facilitators, Volunteers and Households

By the International Federation of Red Cross and Red Crescent Societies (IFRC)

This initiative focuses on an integrated approach to train and mobilize volunteers from the community and carry out disease prevention and health promotion activities in communities. It places emphasis on the involvement, participation and consultation with all stake-holders at the practitioner and grassroots level, and uses short-term health intervention against specific diseases as opportunities to address primary health care components. There is also an approach to working with partners, like local clinics and structures to return to the values, principles and approaches of primary health care.

How and what volunteers and communities will learn depend on the priorities that they identify. These priorities will change when community assessment is carried out at regular intervals. The programme is based upon a flexible approach to ensure community - based participation.

22. Epidemic Control for Volunteers (ECV) Training Manual and Toolkit

By the International Federation of Red Cross and Red Crescent Societies (IFRC)

Responding to epidemics in developing countries has largely been a business of international organizations, such as WHO and INGOs in terms of investigation and verification and of ministries of health (MoH) in affected countries that mobilize their mainly medical structures to respond to the needs of affected populations, contain the infection, and provide medical care and prevention. Other actors can be involved in the process, depending on the context.

The Red Cross and Red Crescent National Societies (NSs) and their volunteers have been involved in community - based health interventions for many years. Those include volunteers spreading health messages in their communities, conducting participatory activities and providing services, such as water and sanitation. However, when acute epidemics occurred, many of the NSs had less clear mandate and activities to participate in because it was seen as medical staff job and because of unavailability of clear and simple guidance. The IFRC built an approach towards more involvement of volunteers in epidemic control on the following assumptions:

- While clinical care is critical, prevention, behavioural change and health promotion are key to containing epidemics;
- Health facilities and medical personnel cannot necessarily reach all communities in outbreaks and health facilities can become overwhelmed;
- In many sorts of epidemics, evidence shows that certain known behaviours taken by community members can limit the spread of the disease and help containment; and
- RCRC volunteers who are trained and work in their local communities, are best placed to deliver health promotion and behaviour change messages, as well as basic services.

23. Health Workforce Financing: Tools for Development

By World Health Organization (WHO)

In January 2008, the Global Health Workforce launched a special task force to focus on the issue of health workforce financial planning and resource mobilization at the country-level.

Health workforce financing is one of the most critical components of scaling up human resources for health. Within the Kampala Declaration and Agenda for Global Action, financing is one of six critical areas for action in order to reach progress. Evidently, increased international funding is needed to bridge the health worker gap. But, equally importantly, domestic governments need to increase their own financing to scale up the health workforce. Significant barriers constrain efforts by governments and donors to increase spending on this input. To overcome these barriers and maximize health worker performance, country policy-makers and international agencies must give greater attention to the economic factors influencing health workers and their implications for the financing of health workforce plans.

Resource Requirements Tool (RRT) is a practical tool that aims to assist countries to estimate and project the costs of their HRH plans; analyze the plans' affordability; simulate "what if" scenarios; and monitor implementation. Experience using the RRT highlights important issues to policy makers and analysts involved with HRH planning. It also shows that complete data needed to make precise estimates of costs and affordability are infrequently available.

24. Healthy Migrants, Healthy Thailand: Improving Health Conditions of Migrants in Priority Provinces of Thailand

By the International Organization for Migration (IOM)

Thailand's relative economic and social stabilities make it a primary destination for many regional migrants who are confronted with difficult political and/or economic conditions. Over two million migrants are estimated to be living or working in Thailand. Approximately one-fifth are legally registered with the Thai Ministry of Labour to work in Thailand. Both registered and unregistered migrants are vulnerable to health risks due to limited or inadequate access to basic health services and poor living conditions. In 1999, the Royal Thai Government approached the IOM to assist with a response to the health issues impacting on both registered and unregistered migrants along Thai-Myanmar borders. IOM then collaborated with the Thai Ministry of Public Health (MOPH) and officially launched the IOM-MOPH Migrant Health Programme (MHP) at the end of 2003.

The goal of the MHP is to improve the health and well being of registered and unregistered migrants in priority provinces of Thailand via the following strategies:

- Strengthening the capacity of relevant counterparts at all levels in various sectors of the Government including MOPH, education, local administrative organizations, Ministry of labour, Immigration, uniformed services and migrants themselves, to provide migrant – friendly health services and to promote ownership of the programme;
- Increasing access to migrant-friendly health services, including a range of primary health care services, environmental health/sanitation and disaster/pandemic preparedness;
- Developing sustainable migrant health programme models that could be replicated elsewhere, within and outside of Thailand;
- Strengthening collaboration between stakeholders including government/non-government and health/non-health sectors and employers of migrants to minimize service duplication and to create an effective multi-disciplinary team approach; and
- Advocating for the development of positive migrant health.

25. The Global Fund to Fight AIDS, Tuberculosis and Malaria

By The Global Fund

The Global Fund to Fight AIDS, Tuberculosis and Malaria is an independent public-private partnership mandated to (i) raise and to disburse substantial new funds; (ii) operate transparently and accountably; and (iii) achieve sustained impact on HIV/AIDS, TB, and malaria.

The Global Fund represents a new approach to international health financing. As a partnership between governments, civil society, the private sector and affected communities, the Fund works in close collaboration with other bilateral and multilateral organizations, supporting their work through substantially increased funding.

The Global Fund is an independent organization, governed by an international board that consists of representatives from donor and recipient governments, NGOs, the private sector (including businesses and philanthropic foundations) and affected communities. In its pursuit to follow the mandate of being a lean funding mechanism, the Fund relies on a wide range of partners to carry out key activities necessary for its functioning and success.

26. The People Living with HIV Stigma Index

By UNAIDS, in partnership with the International Planned Parenthood Federation (IPPF)

The People Living with HIV Stigma Index is a new research initiative - driven and implemented by people living with HIV - to measure stigma and discrimination relating to HIV. It has been developed and is the result of a partnership between the International Planned Parenthood Federation (IPPF), two networks of people living with HIV: the Global Network of People Living with HIV (GNP+) and the International Community of Women living with HIV (ICW), and the Joint United Nations Programme on HIV/AIDS (UNAIDS).

The rigorous quantitative and qualitative research conducted will enable building an evidence base for better informed policies, more effective programmes, increased advocacy and will be an empowering experience for the people living with HIV involved in the process. It will generate a wide range of knowledge and best practices.

This tool has been developed to help measure stigma and discrimination and the impact of interventions, and to document the well-being of people living with HIV over time. Some of the key areas explored in the research include the causes of stigma and discrimination; access to work and services; internal stigma; rights, laws and policies; effecting change; disclosure and confidentiality, treatment; having children; and overcoming stigma.

Non-governmental organizations

27. Community Health Services in Difficultly Accessible Regions

By Terre Des Hommes International Federation

Based on an island survey carried out by Terre des Hommes in the late 1990s, the CIHEP programme was launched to provide preventive and curative health care services for a population of some 165,000 islanders. The programme was first established in 2000 to support the people of the offshore islands in the Bay of Bengal. The island population is isolated from the mainland district headquarters. More than 90 per cent of the people suffer from poverty and landlessness, as many have lost their lands due to river erosion. In addition, the southern part of Bangladesh is frequently hit by cyclones and tidal surges causing many deaths and widespread damage. The most severe ones were the cyclones in 1970, 1985 and 1991. In December 2007, the area was again hit by the super cyclonic storm (SIDR).

The main objective of the programme is to improve the health status of the offshore population by reducing the death rate, maternal death, child mortality and birth rates. At the onset, a self-propelled hospital vessel, equipped with modern diagnostic facilities, was commissioned. The mobile ship clinic, named Shapla, after the national flower of Bangladesh, has been moving from one island to another and conducting six clinics in a week. A team of qualified medical doctors, medical assistants, radiographers, lab technicians and other staff has been providing treatment and diagnostic services, which include X-Ray, ECG and pathological services. Treatment to patients of all ages and sex, check up and advices for pregnant and postnatal women are being provided. Complicated cases requiring further investigation and specialized services are being referred to the Medical College and other specialized hospitals. The number of patients has increased from some 24,000 in 2001 to over 26,000 in 2007. The 26 meters - long hospital vessel has a crew of 13, including the ship's manager, and a medical team of 9. Vaccination programmes are conducted in close co-operation with the local Government and a revolving fund has been established to cover the costs of medicine. Patients also contribute to the services supplied.

28. Heartfile's Health Equity Financing Pilot Project

By Heartfile

In a poverty perpetuating and precipitating context, economic shocks involving catastrophic spending are the most common risks facing households in Pakistan. "Spending catastrophically" means spending of critical savings, selling assets, relinquishing basic needs and/or borrowing, in order to finance healthcare through out-of-pocket payments. Two-thirds of the households recently surveyed in Pakistan reported that they had been affected by one or more health shocks and had spent catastrophically during the last three years. Since the breadwinners of most of these poor households are in the non-formally employed sector, there are difficulties in using insurance as a means of protecting them against the risks of economic health shocks. The other feasible option to protect against catastrophic spending is to enable cash transfers from a "social protection" or "health equity fund". Pakistan's existing social protection mechanisms for health have a very small envelope and suffer from a number of deficiencies, including abuse and patronage in targeting, unpredictability of coverage and a lack of transparency in the use of resources.

This project involves an IT-supported, automated demand side health financing instrument that can be accessed by local health care workers to seek urgent support for those running the risk of spending catastrophically. The pilot is envisaged to enable efficient, timely and well-targeted cash transfers to protect the poor against catastrophic spending on health and has the potential to limit abuse. In addition, a seed “Health Equity Fund” has also been established, as a means of resourcing cash transfers. Software for the technology platform is currently being developed. Once deployed, the custom-made technology platform will enable pre-determined health providers to send requests to Heartfile (the clearing house), who will then ascertain eligibility, verify requests and subsequently authorize cash transfers to underwrite the cost of healthcare.

29. Implementing and scaling up of Harm Reduction (HR) in Afghanistan

By Médecins du Monde

Since April 2006, Médecins du Monde-France (MdM-F) has been implementing the first Harm Reduction (HR) programme in Afghanistan. This programme is located in Kabul and aims to contribute actively to define an Afghan HR strategy, in order to halt and reverse the spread of HIV/AIDS. To fulfill this overall objective MdM-F runs its programme through two sets of activities:

1. Setting up a model care and social centre dedicated to DUs (drug users), which assesses feasibility, acceptability and relevance of HR in Afghanistan and defines Afghan good practices on HR interventions, HIV/AIDS interventions and addiction interventions.
2. Building a national training and resource centre on HIV/AIDS and HR in the same location by training Afghan professionals and stakeholders involved in HR and HIV/AIDS programmes all over the country (nascent Afghan centres), producing and releasing knowledge and analysis on issues related to drug use in Afghanistan, and helping Afghan population to understand challenges related to rising HIV/AIDS epidemic and increasing drug use consumption level, in order to sustain acceptability of HR and HIV/AIDS programmes.

30. My Child Matters Campaign, Cancer Capacity Building Fund

By the International Union Against Cancer (UICC)

Two important UICC projects spotlight our focus on improving access to health and community involvement at the grassroots level - the My Child Matters Campaign and the Cancer Capacity Building Fund.

My Child Matters Campaign

In 2004, the International Union Against Cancer (UICC) and Sanofi-Aventis embarked on a ground-breaking partnership in the fight against childhood cancers under the banner My Child Matters. The objective is to fight childhood cancer in countries where paediatric oncology is still an under-developed field. My Child Matters campaign is the largest and most comprehensive childhood cancer programme in resource-constrained settings.

My Child Matters has already funded 25 pilot projects in 16 countries, covering public awareness, early detection, treatment and follow-up care, professional education, and palliative care. The partnership has launched projects in Bangladesh, Bolivia, Egypt, Honduras, Indonesia, Kenya, Mali, Morocco, Peru, Philippines, Romania, Senegal, Tanzania, Ukraine, Venezuela and Vietnam.

Cancer Capacity Building Fund

In 2007, UICC launched the Cancer Capacity-Building Fund to support efforts to strengthen the work of member organizations in resource-constrained countries in reaching out to local communities with evidence-based activities. In the last two years, the fund has provided support for close to 30 projects in Africa, Asia, Eastern Europe and Latin America. Many of the projects focused on training on developing community events, media advocacy campaigns, seminars, publications and lobbying local governments.

31. Strengthening of Emergency Obstetrical and Surgical Care at Health Facility Level, by Task Shifting - Tigray region, Ethiopia

By Médecins du Monde

Mortality due to pregnancy and child birth is a leading cause of death in Ethiopia, where approximately 22,000 women die during pregnancy or childbirth every year (WHO, UNICEF, UNFPA. Maternal Mortality in 2005). Health services utilization is low with 15 per cent of deliveries taking place in health facilities at the national level and 10.4 per cent in the Tigray region. Although the physician population ratio is 1/35 493 at the national level, it dropped at 1/111 154 at Tigray level (population in Tigray 4 millions).

The challenge of maternal and perinatal mortality reduction has received increasing attention from the Government. It focused on increasing skilled attendance at delivery, as well as access to emergency obstetric care to treat complications in pregnancy and childbirth. To address the shortage of human resources for maternal health, training of health officers in emergency obstetrics and surgical skills was initiated. Usually health officers are professionals with a nursing degree who have gone on to earn a Bachelors degree in three years.

The implementation of the project is the result of a collaboration between the Tigray Health Bureau and Médecins du Monde, with financial support from UNFPA.

Four training sites (hospitals) were identified according to case load and availability of trainers. In some places, preparation of training site meant renovation and equipment inputs. In addition, 14 health facilities have been supported to upgrade infrastructures, equipment and supplies for surgical services.

Surgical teams were trained for surgery, as a whole, that included emergency obstetrics care (one team is one health officer trained for surgery, one nurse for anaesthesia and another nurse for operating room). During the nine - month training period, the majority of credit hours were dedicated to practical experience through/or training and ward rounds/bedside teaching with 10 per cent of time spent on lectures. Each student was provided with a logbook, which outlined the minimum number of procedures that they should assist and perform with, or without, assistance. A training recognition was planned as certification and remuneration are linked. In Ethiopia, each three month period of training affects the eligible salary increment.

32. Sustaining Leprosy Control Measures in the Public Health System to ensure Quality Care as a Right of the People affected by Leprosy

By Anesvad

Leprosy is a nerve and skin disease caused by mycobacterium leprae. Its unfortunate consequences of disability and deformities have led millions of people economically dependent and socially ostracized. Today, disease burden has reduced with less number of new cases, thanks to the high cure rate during the last three decades of universal multi drug treatment (MDT).

A specialized vertical programme, based on the Survey, Education and Treatment (SET) methodology was implemented nationwide for more than five decades in India. The Government of India, in partnership with international leprosy relief agencies (ILEP and others), helped to reduce the actual number of people affected by leprosy to 1 case per 10,000 population at the national level. Despite the higher levels at sub-national level, the Government declared elimination, which directly affected the public opinion and resources for the programme.

This declaration resulted in a major policy change by integrating leprosy in the public health system and enlisting its personnel for leprosy work. Multiple health care providers in the public health system are involved and expected to provide treatment and care of individuals affected with leprosy. Although a wide network of general health care system is available in the country to make leprosy services available at primary health care level, poor governance and prioritizing leprosy services are of great concern. The ill-equipped public health systems with inadequate health personnel, who are already overburdened with several other diseases are hampering the integration process. This situation has

created a vacuum and physical barriers in offering quality care to the leprosy affected persons.

33. Technologies for Sustainable On-site Sanitation for Improved Global Public Health

By Sulabh International Social Service

The methodology of this initiative is based on research, innovation of sustainable, affordable/cost-effective eco-friendly, technically appropriate and culturally acceptable on-site sanitation technologies and their implementation on large scale in individual houses and at public places in urban, peri-urban and rural areas in India.

The initiative uses "hardware" and "software", i.e., construction of Sulabh toilets/conversion of dry toilets to pour-flush in individual homes and construction and maintenance of public toilet complexes on pay-and-use basis in market places, at bus stops, opposite railway stations, near high-rise buildings, etc., for recycling of human waste, as hardware. It also focuses on demonstration and dissemination of information by using awareness programmes, motivation and education of householders to construct toilets, information about the benefits of sanitary toilets, training programmes on health, hygiene and sanitation and sensitizing policy makers and functionaries thus, changing the mind set of people and bringing about a paradigm shift in the perception of toilet and a demand for sanitation.

Sulabh International Social Service also aims to work in close collaboration with the Government and its agencies, local bodies and the community.

Private Sector

34. Children Without Worms: Partnership for Treating and Preventing Intestinal Worms

By Johnson and Johnson

Soil-transmitted helminthiasis (STH) is a disease of poverty. It is one of the neglected tropical diseases affecting the world's poorest and most vulnerable populations. Infected and at-risk populations lack access to health education, sanitary latrines, and potable water and are, therefore, continuously exposed to the worms and eggs in their environment. The effects of STH are especially harmful for children, who endure the highest rates of infection. These children suffer from diarrhea, fatigue, abdominal swelling, and pain. Left untreated, STH may lead to impaired cognitive development, reduced school attendance and performance and, ultimately, decreased productivity as adults – all of which perpetuate the cycle of poverty.

Children Without Worms is a partnership between Johnson and Johnson and the Task Force for Global Health. Currently entering its third year, the programme supports global efforts to reduce the burden of STH in children, who are most severely infected or at high risk of infection and have limited access to safe and effective treatment. Children Without Worms works with national STH control programmes in Bangladesh, Cambodia, Cameroon, Cape Verde, Lao People's Democratic Republic, Nicaragua, Uganda, and Zambia.

The strategic approach of Children Without Worms is to leverage the donation of mebendazole from Johnson and Johnson to advocate for a comprehensive and sustainable control of STH. Specifically, Children Without Worms: (i) Donates mebendazole to national STH control programmes that combine prevention (i.e., hygiene education and increased access to potable water and sanitary latrines) with regular mass deworming treatment; (ii) Advocates for resources to promote hygiene education and access to sanitary latrines and potable water; and (iii) Partners with organizations already working in health education and water and sanitation sectors to ensure that donated mebendazole is distributed in an environment that maximizes impact.

The strategic approach builds on the strength of partners, promotes sustainability, and enhances collaboration and opportunities for reducing costs and utilizing financial and technical resources effectively.

35. The REACH Programme

By Siemens

Through its REACH programme - Resources Embracing Africa with Care and Hope - Siemens Health care Diagnostics is working with funding agencies and local partners to expand access to cost-effective healthcare in Africa. With the REACH programme, Siemens is able to deliver HIV viral infectious disease management in settings that are too inhospitable for some other systems. From total solutions to on-site and off-site operator trainings, Siemens offers the right technology and the right pricing for Africa at this critical moment.

HIV/AIDS infection remains at plague levels in Africa. Due to the lack of access to appropriate health care, as many as 90 per cent of Africa's AIDS victims risk early death. Siemens' REACH programme delivers HIV disease management: the right technology, right training and the right pricing.

Notes

- 1 For more information, visit:
<http://www.un.org/esa/coordination/Alliance/documents/website/PR%20Infopoverty%20web.pdf>; <http://www.occam.org/indexita.htm>
- 2 For more information, visit:
http://www.medetel.lu/download/2009/parallel_sessions/abstract/day2/towards_a_specific_ehealth_data_tool.doc;
<http://www.portailtelesante.org/sections.php?op=viewarticle&artid=233>
- 3 For more information, visit:
http://www.bd.com/globalhealth/initiative/pdfs/BD_TB_Case_Study_Final.pdf

Chapter 9

THE HIGH-LEVEL SEGMENT MINISTERIAL ROUNDTABLE BREAKFASTS

Overview

During ECOSOC's high-level segment from 7 to 9 July 2009, ministerial roundtable breakfasts were organized and sponsored by several United Nations agencies. Stakeholders were brought together from governments, civil society, including NGOs, academia and foundations, to discuss various aspects of the overall theme of the segment.

A number of diverse topics were discussed at these roundtable breakfasts. These included public health and pharmaceuticals, AIDS vaccine research, gender and health in relation to women's migration, the impact of population ageing on public health, the role of public-private partnerships in digital health and development, the protection of women and newborns and non-communicable diseases and injuries in developing countries. The rich and useful discussions at these high-level roundtables reflected in this chapter helped accentuate the Council's ability to highlight the progressive and multifaceted efforts to help achieve the internationally agreed development goals, including the Millennium Development Goals (MDGs).

Global public health- high-quality, low-cost pharmaceutical production in developing countries emphasizes the need for innovative programming and policy-making designed to improve the pharmaceutical industry in developing countries and stresses the local production of pharmaceutical products, as well as maintenance of international quality standards.

Accelerating efforts to save the lives of women and newborns addresses the fact that progress toward reducing child mortality and improving maternal health is not proceeding at a sufficiently acceptable pace, due to a lack of functioning health systems, shortage of human resources and funding, and a deficiency in horizontal programming. Because these issues affect women, it is emphasized that women in developing countries should be incorporated into programming and given the resources to identify and resolve problems surrounding maternal health in their communities. The creation of improved and enforceable policies concerning women and newborn health is also highlighted.

Digital health and development in Africa and least developed countries (LDCs): Role of public and private partnerships emphasizes the crucial role of information and communications technologies in the development of health services and systems in developing countries, specifically in regard to achieving the MDGs. Strengthening existing health systems by the use of digital health care and information technology is also stressed.

AIDS vaccines: The way forward acknowledges the advancements in technology and logistics that have improved access to affordable treatment options for HIV/ AIDS, and emphasizes that a comprehensive approach to tackling the HIV epidemic must ultimately

include an AIDS vaccine, despite disappointing previous attempts. The discussion also highlighted the need for greater inclusion and participation of Africans and African nations in the effort to develop an AIDS vaccine. The development of a single African drug agency to promote standards, manufacturing, and transparency was also discussed.

Addressing non-communicable diseases and injuries: Uniting development and public health agendas examines the significance of non-communicable diseases and injuries in developing countries and its socio-economic impact through the perspectives of both public health and development. Also highlighted is the unfortunate omission of non-communicable disease and injuries from the MDGs. Discussions also included perspectives of both the donor's and partner country's points of view. The need to identify appropriate proposals to address these public health issues is also stressed.

The implications of population ageing for global public health focuses on the problems that ageing populations face, touching upon both communicable and non-communicable diseases, as well as discrimination within the medical profession against ageing persons. The promotion of respect and equitable attention to the health needs of older persons is also emphasized.

Promoting migrant women's health needs to achieve MDGs: The case of violence against women and girls focuses on the feminization of migration and the vulnerabilities many women face as migrants, including exploitation, discrimination, sexual and physical violence, disease, psychosocial health, and reproductive health. The development of universal health care for all migrants and its potential implications is highlighted.

Global Public Health - High-Quality, Low-Cost Pharmaceutical Production in Developing Countries¹

By the United Nations Industrial Development Organization (UNIDO), the United Nations Conference on Trade and Development (UNCTAD), the World Health Organization (WHO) and the International Centre for trade and Sustainable Development (ICTSD)

A. Issues paper

At the September 2005 United Nations General Assembly, the Heads of State and Government of the United Nations Member States reiterated their determination to ensure the timely and full realization of the MDGs by 2015. Despite this commitment, the MDGs are far from being realized. One-third of the global population lacks access to needed medicines and the situation is worse in the poorest countries, where as much as 50 per cent of the population lacks access.²

Effective promotion of affordable access to medicines in developing countries depends on a multitude of different factors. In particular, access is made difficult by numerous challenges, such as insufficient distribution infrastructure, lack of medical personnel, trade and fiscal barriers, inadequate health care systems and unaffordable prices for a large proportion of the population. There have been important philanthropic initiatives but the magnitude of the health crisis faced by developing countries requires consideration of more sustainable, long-term solutions as well.³ Particular difficulties arise in the case of diseases affecting mainly developing countries, such as tuberculosis and malaria, where market mechanisms have not provided sufficient incentives for the rapid development of effective treatments ("poverty-related", "tropical" or "neglected diseases").

One possible means of helping to address the problems associated with access to medicines in developing countries is the creation of local production and supply capacities. Promoting the local production of health products and related transfer of technology in developing countries may contribute to a sustainable and long-term solution to the challenges of medical innovation and access. Among other things, such endeavours have been credited with the potential to build health security, increase the reliability of supply, decrease reliance on imports, lead to lower prices, and encourage development and production that is more suitable for respective regions.

In the context of promoting public health at the international level, local production and technology transfer have been widely recognized and supported. For example, among the key areas identified for investment in the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA) are "capacities related to science and technology, local production of pharmaceuticals, clinical trials, regulation, intellectual property and traditional medicine." (emphasis added)⁴ The GSPOA also calls for supporting North-South and South-South development cooperation, partnerships and

networks, in order to build and improve transfer or technology related to health innovation.⁵

The importance of supporting efforts by developing countries to strengthen local pharmaceutical production has also been recognized in developed countries. In this regard, the OECD High-Level Forum on Medicines for Neglected and Emerging Infectious Disease in June 2007 recommended:

"[...] 3. Supporting developing countries-led efforts in strengthening their own health, local production and research systems [...]. In particular: [...] Taking steps to strengthen the capability of developing countries to manage issues of intellectual property, including using available flexibilities to the fullest extent, and to build sustainable networks and capacity for global research."⁶

The European Parliament in 2007 urged the European Union and its Member States to:

"take additional measures [...] to facilitate and increase the production of pharmaceutical products by the developing countries themselves [...] [and] to provide concrete financial support for [...] local production of pharmaceuticals in all developing countries, especially LDC [...]."⁷

UNCTAD and UNIDO have been specifically identified among the stakeholders for implementing the GSPOA. UNCTAD and the International Centre on Trade and Sustainable Development (ICTSD) have a long-standing collaboration in the area of intellectual property (IP) through their joint project on IPRs and sustainable development. In this context, WHO, UNCTAD and ICTSD are examining, with support from the European Commission, health-related research, development, and production capacity in developing countries, including the LDCs. In so doing, UNCTAD draws on experience gained in the course of a project on the local production of pharmaceuticals in developing countries, which it is implementing in collaboration with UNIDO, under an initiative headed by the Federal Ministry for Economic Cooperation and Development (BMZ) of Germany. One of the beneficiary countries of this initiative has been the Federal and Democratic Republic of Ethiopia, where some domestic producers of pharmaceuticals have been supported through BMZ funding and where UNCTAD provided legal advice and organized, in collaboration with Ethiopia's Engineering and Capacity Building Programme, a regional workshop on the role of intellectual property rights in the promotion of local pharmaceutical production.

Starting off with a number of pharmaceutical sector studies carried out on developing countries in Africa and Asia in 2007, UNIDO has since been implementing a global project to support the commercially viable manufacturing of high-quality medicines. Advisory, capacity-building and promotional activities at enterprise, institutional and policy levels are targeted specifically at products used to combat HIV/AIDS, malaria and tuberculosis. Private sector efforts to reach international quality standards, including through business partnerships, receive prominent attention in the assistance provided.

The purpose of the ministerial breakfast roundtable is to discuss the potential of investment and transfer of technology in viable local production of health products in developing countries and LDCs, alongside existing initiatives to promote access to medicines and the use of available flexibilities in IPR instruments for this purpose.

B. Summary of discussions

The ministerial roundtable breakfast was held on 7 July and was co-chaired by Mr. Petko Dragonov, Deputy Secretary-General, UNCTAD, and H.E. Fisseha Yimer, Ambassador, Permanent Mission of the Federal and Democratic Republic of Ethiopia to the United Nations.

Participants discussed the need for local production of pharmaceutical production as an option for addressing the lack of access to high-quality affordable medicines in developing countries. As a complement to existing philanthropic and industry initiatives, local production can be viewed as a means to increase pharmaceutical-related investment and transfer of technology in developing countries. Local production may not be economically viable in every developing country and factors that need to be in place, in order to prepare for viable production include an effective regulatory framework, political stability, conducive economic conditions, capacity to reach quality standards, and delivery capacity. A joint UNCTAD/WHO/ICTSD project, supported by the European Union, seeks to identify those factors that need to be in place in order to prepare the ground for economically viable local production of pharmaceuticals.

Also highlighted was the intergovernmental process which led to a global consensus in the areas of public health, innovation and intellectual property (IP). The outcome of intense debate and negotiations, the Global Strategy and Plan of Action on Public Health, Innovation and IP (GSPA) was adopted at the World Health Assembly in May 2008. The GSPA will address the immediate need for equitable access to good quality, affordable medicines and the long-term need to stimulate and sustain innovation. Within the context of implementation of the GSPA, it was noted that the WHO had launched a joint project with UNCTAD and ICTSD to undertake studies on the opportunities and challenges that exist in the areas of local production and technology transfer.

Also addressed was the role of local pharmaceutical industry in developing countries for enhancing access to essential medicines. Achieving and maintaining international quality standards, as well as commercial viability, are the two main criteria that not only capture the complexity of a sustainable local medicines production, but – if adhered to – also represent a way of reconciling both the public health and the economic development agendas. Highlighted was UNIDO's contribution in support of pharmaceutical sector growth that comprises advisory and capacity-building interventions at policy, institutional and sector/plant levels. The assistance includes multi-stakeholder consultations aimed at mutually agreed pharmaceutical industry development strategies, the strengthening of pharmaceutical sector business associations and providing support for company upgrading towards international standards.

Participants also discussed the role of intellectual property in technology transfer in relation to the local production of pharmaceuticals in developing countries. Empirical evidence on the role of IP in technology transfer remains inconclusive; the volume of transferred technologies may sometimes rise with improved levels of IP protection but, in other cases, the absence of patent protection played a role in local production development. This may be due to the fact that technology transfer is a multifaceted process where IP is just one among a number of factors that influence it. Further study is

needed in several areas, including how to create a suitable environment for transfer and access and how to make developed country incentives more effective for technology transfer, particularly to LDCs. The initiation of a joint UNCTAD/WHO/ITCSD project could hopefully be able to answer some of these critical questions related to local production of pharmaceuticals.

With regard to national level initiatives, participants were provided with a briefing on the current situation of local manufacturing in Ethiopia. While presently there is a significant reliance on imported medicine, local production is growing, with the support of the German agency GTZ. Health reform, a focus of a national governmental reform programme, includes implementation of an institution, which aims to ensure availability of locally produced quality drugs. Also, the Sino-Ethiopian Associate PLC could offer a workable model of collaboration involving investors of developing countries and technical expertise and support by advanced nations. However, reliance on imported raw materials and local production limited to secondary manufacturing are challenges to local production.

In the ensuing discussion, participants agreed on the importance and timeliness of the GSPA and displayed a wide variety of views on the future role of the IP system and alternative incentive systems in the development of cures for tropical diseases. Some participants stressed the importance of fully implementing the health-related flexibilities available under the TRIPS Agreement, and the current failure of many developing countries to do so, for various reasons. Others emphasized the need to build local producers' technical capacities, in order to effectively benefit from partnerships with the multinational pharmaceutical industry. Concerns were also raised with respect to some WTO Members' domestic IP enforcement legislation as affecting the timely delivery of generic drugs to needy developing countries.

In conclusion, participants noted the need for market-based but development-oriented policies for the promotion of technology transfer and foreign investment in developing countries and, in that context, the joint work of UNCTAD, WHO and ICTSD, under a new EU-funded project, was welcomed as an opportunity to examine the ways particular countries address this important issue.

Accelerating Efforts to save the Lives of Women and Newborns⁸

By the United Nations Fund for Population Activities (UNFPA), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), and the World Bank

A. Issues paper

“We cannot afford, in this time of crisis, to squander our investments, to abandon our drive for greater balance in this world, which I firmly believe is a marker of civilized society. I am calling on all governments and political leaders to maintain their efforts to strengthen and improve the performance of their health systems, to protect the health of the people of the world and, in particular, of those most fragile, in face of the present financial and economic crisis.” (WHO Director-General Ms. Margaret Chan)

Overview

In the last decade, political and financial support for global health has doubled. This increase has been concomitant with the adoption of the MDGs – and the three health-related goals at its core. While this increased support has assisted many, unfortunately there has not been sufficient emphasis on MDG 4 to reduce child mortality and MDG 5 to improve maternal health, which requires long-term sustained focus. In recent years, support has been growing for these issues; however, the current economic climate - if it endures - poses challenges for maintaining and increasing the political and financial support to countries to achieve these targets.

While it is clear that there is a need to respond to the financial crisis, it is also important to ensure that sustainable development and its key pillars of education and health remains in focus. It is estimated that the current crisis could result in an additional 90 million people a year living in extreme poverty. Investing in sustainable development is, therefore, even more crucial, as people lose or have their source of income reduced and become more vulnerable to poor health. Women represent 70 per cent of the world's poor and will likely be most affected by the economic downturn. The World Bank has identified 33 developing countries, where women and girls in poor households are particularly vulnerable to the effects of the global economic and food crises. These are also countries with some of the highest maternal and child mortality rates.

The High-level Task Force on Innovative International Financing for Health Systems recently observed that there is more funding needed from domestic and external resources and more effective utilization of current and new funding, including that of well-resourced disease programmes, to ensure that rapid progress is made towards all the health-related MDGs and the MDGs, in general. This funding would mean that health systems in developing countries are strong enough to progressively realize obligations on the right to the highest attainable standard of health. Unfortunately, MDG 5 and the newborn health targets of MDG 4 are among the farthest behind in terms of achievement.

Very few low-income countries are currently on track to achieve these goals by 2015. Some are making progress but not rapidly enough for the 2015 timeline, while others are falling far behind. Sub-Saharan Africa, South Asia and countries emerging from conflict are particularly struggling to make progress in this area.

One reason these goals lag behind is because addressing maternal and newborn health relies upon functioning health systems, including primary health care with skilled professionals, referral level care with basic surgery and emergency transportation, and targeted efforts to reach vulnerable groups. To prevent maternal death and disability, every woman must have access to the full spectrum of quality reproductive health services. Key components, such as skilled delivery care and quality emergency obstetric and newborn care cannot be assured without a system that can function at all levels, 24-hours per day, with a sufficient number of skilled health care workers. To date, investments in health have often been fragmented and infrequently focused on the overall functioning of the main mechanism for delivery of health care – the health system.

Challenges

Reducing unintended pregnancies through access to family planning is vital to improve maternal and newborn health. It is estimated that access to family planning alone could reduce maternal death rates by 20 to 35 per cent and child deaths by more than 20 per cent. In a period of fiscal constraint, it is also one of the most cost-effective interventions. Studies show that each dollar invested in contraceptive services can avert between \$1.7 and \$4 in expenditures on maternal and newborn health and as much as \$31 in social services and other costs. Access to family planning also contributes to reducing poverty, as families with fewer children are able to free resources for education and health and mothers have more time for paid labour.

Often populations who are most vulnerable lack access to the health systems. Maternal mortality is a stark example of this unequal access – as the poorest women in the poorest countries are the least likely to have the care they need during pregnancy and childbirth. In low-income countries, women in the poorest quintile are six times less likely than women in the richest quintile to have access to a skilled birth attendant during delivery. Rural areas also frequently lack sufficient facilities, personnel and transport options. It is, thus, critical that measures to ensure financial and geographic access are undertaken and that the economic crisis does not result in increases in the costs of health care. Geographic access requires adequate distribution of health facilities and personnel, collaboration with the transport sector to ensure affordable transport options and promotion of community-based solutions. Financial access requires innovative mechanisms to ensure that delivery care is affordable.

Adolescents also often lack access to sexual and reproductive health services, despite the fact that each year an estimated 14 million adolescent girls give birth. Adolescent pregnancy, which is most prevalent in sub-Saharan Africa and parts of Asia, brings risks to the mother and the baby. Adolescent girls are twice as likely to die in childbirth, as women in their twenties and their infants are less likely to survive. Efforts to delay pregnancy through delaying marriage and increasing adolescents' access to family planning will have not only positive health benefits but also increase girls' opportunities to continue education. Strategies to ensure that the system is reaching and meeting the

needs of adolescents will be critical, including sexuality education, male involvement and community mobilization.

Many countries have already developed or are developing national health plans, which should be effectively funded and implemented with plans for scaling up to universal coverage, ensuring the continuum of reproductive, maternal and newborn health care from community to facility and access to key services, such as family planning, skilled birth attendance, and emergency obstetric and newborn care. The financial crisis will put pressure on governments to cut expenditure, making it more difficult to retain the right balance of essential services. Governments are urged to allocate 15 per cent of their budgets to health and not cut down. International cooperation and official development assistance (ODA) is even more crucial than it has been before. Progress has been made in harmonization of support to countries but commitments to increase donor investments in health in low-income countries will also need to be fulfilled to make these plans a reality.

The High-level Task Force on Innovative International Financing for Health Systems recently noted that strengthening the health system to ensure rapid progress towards the health-related MDGs and other health goals would cost an additional US\$36-49 billion (\$24-32 per capita) per annum by 2015. They have estimated that this level of health expenditure in 2015 would save the lives of over 5 million children and babies and provide skilled care at birth for 56 million women, in addition to contributing to other health-related goals, such as MDG 6 to combat HIV/AIDS, malaria and other diseases.

Partnerships

Partnerships and coordination among actors at all levels will be necessary to achieve these goals. In the area of global health, leaders of eight agencies have come together in the 'H8'⁹ to align and reduce fragmentation. They have agreed that the best mechanism to support countries in achieving their health goals is to support the development and implementation of national health strategies and plans. The International Health Partnership Plus aims to harmonize the workings of different health actors in support of national plans at the country level.

Way Forward

Specifically on maternal and newborn health, UNFPA, UNICEF, WHO and the World Bank have jointly pledged to intensify their support and to work together to support countries to achieve MDG 5 and the newborn health targets of MDG 4. The four United Nations agencies pledged, over the next five years, to enhance support to countries with the highest maternal and newborn mortality. We pledged to support countries' national health plans to strengthen health systems in achieving the two MDG 5 targets of reducing the maternal mortality ratio by 75 per cent and achieving universal access to reproductive health by 2015, and the newborn target of MDG 4.

Women form a fundamental part of society. Newborn children are the future of society. The survival of women and newborn children are a key determinant for the achievement of the MDGs. We cannot continue to neglect their health needs, if we want to achieve sustainable development. Now, more than ever, we need to ensure continued progress towards achieving MDGs 4 and 5.

Some issues for consideration

- What are successful best practices where countries have made strides in building health systems to deliver on MDG 5? How can these best practices be adapted and applied in other settings?
- What role should various stakeholders, including governments, donor agencies, United Nations entities, international organizations, the private sector and civil society organizations, play in supporting national efforts to achieve MDGs 4 and 5 in policies/strategies/actions at the local, national, regional and international levels and in ensuring sufficient allocation of resources (human, financial)?
- How can the gains be safeguarded while, at the same time, adequate levels of support be sustained in the face of the financial crisis?
- What are the sources to step up capacity, emphasizing south-south cooperation and triangulation of support from northern institutions?
- How do we ensure political, operational and community leadership, engagement and accountability for results on achieving MDGs 4 and 5?
- How can we move forward together to address challenges?

B. Summary of discussions

The ministerial roundtable breakfast held on 7 July, was co-chaired by Ms. Joy Phumaphi, Vice-President of Human Development Network, World Bank; Ms. Mari Simonen, Deputy Executive Director, UNFPA; Ms. Daisy Mafubelu, Assistant Director-General, Family and Community Health, WHO; and Ms. Cecilia Lotse, Director, Governance and Multilateral Affairs, UNICEF.

Participants highlighted how progress towards MDGs 4 and 5 is not proceeding fast enough and the global recession is only making the situation worse. Sub-Saharan Africa is particularly struggling to make progress and issues, such as youth access to reproductive health services and delaying pregnancy through tackling early marriage are critical. Working in partnership with United Nations agencies as catalysts is critical for making progress towards the MDGs.

Other participants in the roundtable discussions, guided by the issues paper, pointed out that addressing maternal and newborn health requires functioning health systems that can provide skilled care at birth, quality emergency obstetrics and newborn care and universal quality reproductive health services for all women across the lifecycle. There is need for systemic change for long term sustainability. Targets, indicators and monitoring need to be clear with the availability of emergency obstetric care, as a cornerstone of a functioning health system. To date, investments in health have often been fragmented and were not focused on the overall functioning of health system as the main mechanism for delivery of health care. Another recurring theme was the need for an integrated approach to strengthening health systems that moves away from vertical programming (i.e., treating HIV/AIDS not in isolation but as central to achievement of MDGs 4 and 5 in the high-burden countries).

A joint statement of WHO and UNICEF was introduced, recommending home visits by a skilled health worker during a baby's first week of life (the most critical time for newborns) as a complementary strategy to care in health facilities to improve newborn survival. Women's and community empowerment should serve as cornerstones of maternal and neonatal health programme design. Women, families and communities should have a voice in identifying the problems, defining solutions, and monitoring implementation.

Within health systems, the shortage of human resources was highlighted as an issue. There is a need to develop national workforce plans for the short term to address acute human resource needs and mid-term plans that include training strategies for more sustainable outcomes. It is likewise important to institute legislation and regulations, as well as to offer incentives and guarantee proper working conditions to prevent health worker migration. Adequate policies in northern recipient countries to deal with ethical recruitment in sending countries in the South are essential. Task shifting needs to be further explored and better documented as a possible instrument for addressing the human resource crisis in the short term. In this regard it is also critical to ensure integration of maternal and newborn health services, linking to programmes for nutrition, prevention of malaria and mother to child transmission of HIV.

Rapid progress towards MDGs 4 and 5 requires more funding than currently available. Several participants mentioned the importance of not cutting health budgets and for international cooperation during the current financial crisis. There is an effort underway between GAVI, the WB and GFATM to create a joint funding window for health systems strengthening. This framework needs to involve agencies that are operational on the ground, such as UNFPA, UNICEF and WHO and other existing channels to scale up delivery of funds devoted to maternal and child health.

Several successful country examples were presented. In Indonesia, the maternal mortality ratio was reduced from 307 in 2003 to 220 in 2007. Contributing factors in this progress were strengthening of primary health care and the integration of health programmes and pro-poor and pro-employment programmes (in particular, in light of the economic crisis). China has experienced a dramatic decrease in its IMR and MMR during the last 60 years, from an IMR in 1950 of 200/1000 to 15/1000 in 2008 (there are, however, huge variations within the country). Reasons for China's success include efforts to strengthen routine measures, such as antenatal care and family planning combined with more campaign-like interventions, in order for all pregnant women to deliver in hospitals. These initiatives have been realized by ensuring that each township has a hospital and trained health workers. Japan noted similar improvements over the past 50 years to ensure free access to care from pregnancy through delivery and post-partum care for mother and baby.

South-South collaboration was seen as an important way to improve capacity and health outcomes. There are solid examples of this particularly from Latin America, where some countries have been able to improve indicators despite poor environments, showing that it is not only a matter of money but also of political commitment and vision at the national level. China is considering substantially increasing its support for the achievement of MDGs 4 and 5 in Africa and seeks to work in partnerships for this.

Partnerships and coordination among actors at all levels is necessary to achieve MDGs 4 and 5. The joint work between WHO, UNFPA, UNICEF, and the World Bank on accelerating efforts to save the lives of women and newborns is appreciated and there is obviously a need for greater coordination between the four agencies. This coordination should, however, remain "light" and focus should be on action and implementation in country.

Digital Health and Development in Africa and Least Developed Countries (LDCs): Role of Public and Private Partnerships¹⁰

By the United Nations Office of the Special Adviser on Africa (OSAA), the United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States (OHRLLS), the United Nations Office for Partnerships (UNOP), the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the Global Alliance for ICT and Development-United Nations (GAID)

A. Issues paper

Background

On September 22 2008, the United Nations¹¹ in cooperation with business and civil society partners¹² held an official side meeting as part of the high-level event on African development needs during the United Nations General Assembly, entitled “Digital He@lth and African Development”. In 2009, the Annual Ministerial Review (AMR) of the United Nations Economic and Social Council (ECOSOC) held at United Nations Headquarters in Geneva on 6-9 July took “global public health” as its overarching theme. This was supported by an ECOSOC Africa Regional Ministerial Meeting on “e-Health use of information and communications technology”, in Accra on June 10-11.

A unique opportunity exists to maximize multi-stakeholder partnerships among governments, donors, business, civil society and international organizations in the debate on the future of the global public health agenda through the ECOSOC process. This is of vital importance because Africa and the LDCs as a whole, are the furthest off track to meeting the MDGs on reducing child mortality, improving maternal health and combating infectious disease (MDGs 4, 5 and 6). Yet, experiences from other continents, as well as recent progress in several countries in the region, prove that the goals can be achieved across Africa and LDCs.

Nevertheless, support for rapid scale up of proven interventions, as well as critically needed investments in basic healthcare systems remains insufficient. In most African countries, the basic health infrastructure, human resources, equipment and supplies are inadequate to provide essential maternal, child and reproductive health services, and to prevent, control and treat infectious diseases¹³. In addition, it is clear that the overall burden of care on the poorest countries and populations will be seriously compounded in the coming decade by the increases in cases of chronic non-communicable diseases and the diseases of climate change. So how can we move forward for the dramatic improvement of health outcomes and human development in Africa and the LDCs?

For the first time in history, the world has the knowledge and the means to address global health issues in ways it has never been prepared to do in the past. New technology has transformed communication and access to information. The ripple and network effects resulting from the convergence of computer, telephone and television have already moved far beyond the generic platform technologies of mobile communications and the internet. They have also led to rapid acceleration of knowledge and discovery in life science in areas such as genomics, biotechnology, and nanotechnology. The coming together of all these related technologies with the health sectors at the nexus of digital health (including eHealth and mHealth) has profound implications for development policy making and resource mobilization.

However, as low cost internet and mobile technology at last nears critical mass even in the poorest countries, unleashing the power of technology for health in resource poor settings will require a radical rethinking of current approaches. Specifically, it will require a laser-like focus on the holistic strengthening of health systems that eschews purely vertical or horizontal strategies. It will require an “all government” approach that transcends ministerial silos and positions digital health at the forefront of national economic and social policy. It will require the full engagement of business and civil society in a “global partnership for development, particularly with the ICT and pharmaceutical sectors (MDG 8).

The ministerial breakfast roundtable will address child mortality and maternal health, HIV/AIDS and other infectious and communicable disease, the diseases of climate change, neglected tropical diseases, health systems and services, and chronic non-communicable disease, seen through the lenses of available technology and development strategies and solutions for scaling up critical interventions. Results-based outcomes from the meeting will include delivery of the preliminary findings of the Digital He@lth Initiative, mHealth Alliance, Text for Health Initiative, among others, in promoting a strategic framework for development cooperation in the fields of health, technology and development.

Questions for consideration

- How are governments and relevant actors in the regions implementing an integrated or holistic policy for national health systems? Where is the level of government and donor coordination?
- What can healthcare learn from leapfrog ICT in other sectors?
- For every dollar of investment in science and technology, what does the impact on healthcare outcomes look like? Is there a threshold that we have to reach?
- How can we engage non-traditional partners in the private sector towards meeting these goals?
- What is the role of innovative public-private partnerships and market forces in generating local and global responses, and how do these relate to Goal 8 Target 17 and 18? How do we measure impact?

- How do we arrive at a common definition of digital health and how can generic platform technologies enhance health and healthcare value chains by inviting new participants and actors?
- WHO estimates Africa is short of 1.5 million health workers. What impacts would cell phones and laptops in the hands of every health worker have in the formal and informal workforce sectors? How do we deal with the problem of migration?
- What emerging technologies can help scale healthcare to rural and remote areas? How can the diversity of technological solutions currently employed be improved and guided towards developing more cohesive approaches?
- How can the notion of public health goods be pursued beyond the global public goods of knowledge, science and technology transfer and IPR-free drugs?
- How can R and D efforts in overlapping MDG fields be aligned towards common goals without compromising the diversity of approaches?
- Is health micro-credit linked to micro-finance, mobile or otherwise, the way forward in Africa and the LDCs?
- How can the inter-linked development goals in health, education, enterprise, public administration and environment be leveraged for common gain via technology?

B. Summary of discussions

The ministerial roundtable breakfast took place on 7 July 2009, and was co-chaired by Mr. Cheikh Sidi Diarra, Special Advisor on Africa and High Representative for Least Developed Countries, Landlocked Developing Countries and Small Island States, and Dr. Tim Evans, Assistant Director-General, Information, Evidence and Research of the World Health Organization. The discussion was co-moderated by Dr. Najeeb Al Shorbaji, Director, Knowledge Management, World Health Organization, and Mr. Denis Gilhooly, Principal Advisor, United Nations Office for Partnerships, and Executive Director, United Nations Digital Health Initiative.

Making the case for digital health and development

Participants recognized the critical role of information and communications technologies (ICT), as well as pharmaceutical technology, in the delivery of health services and the strengthening of health systems for the achievement of the health-related MDGs and beyond. Yet, it was stressed that the case for wide scale expansion of investment in these technologies must still be made to many key stakeholders. While there had been an explosion of innovation and investment in the digital world, there was still a need for mechanisms to evaluate the efficacy of digital solutions.

Ways and means should be identified on how to scale up the use of digital health solutions that have been proven to work. Identification of replicable lessons and key gaps must be woven into a viable economic and social model to convince leaders in government, civil society and the private sector to step up to the plate. Leapfrogging was not a given in terms of the benefits deriving from the application of digital technologies,

and making the case will require a unique marriage of the technical and the political, stressing the importance of evaluating where the real efficiencies and inefficiencies reside.

Governance and stewardship

There was a critical need to think more systematically about governance and stewardship. The development of a National Digital Health Policy and Strategy that brings together the health, development and technology sectors to articulate ICT implementation policies and plans for public health — including e-Health and m-Health — and based on identified national health priorities was urgently needed. Mainstreaming and coordination of digital health approaches across national ministries increasingly require designation of a high-representative or coordinator representation at the highest level of government.

Alignment of roles and responsibilities of – and opportunities for - multiple stakeholders across public-private-partnerships was also seen as vital to accelerated economic and social equities, as well as improved health outcomes. At both the national and international levels, all players should understand that, in areas as diverse as efforts toward interoperability or privacy protection, some relevant regulation and standardization would almost certainly be needed. This was even more important with the sudden proliferation of new players in the global health and digital health landscapes.

Scaling up to meet the MDGs and beyond

While essential to meeting the health-related MDGs, it was stressed that support for rapid scale up of even proven interventions, as well as critically needed investments in basic healthcare systems remains insufficient. In Africa and the LDCs, the basic health and communications infrastructure, human resources, equipment and supplies are inadequate to provide essential maternal, child and reproductive health services, and to prevent, control and treat infectious diseases. In addition, it is clear that the overall burden of care on the poorest countries and populations will be seriously compounded in the coming decade by the increases in cases of chronic non-communicable diseases and the diseases of climate change.

To address these challenges and, specifically in the contexts of sub-Saharan Africa and the LDCs, strong empirical data was essential to know where the scale up potential for digital technologies lay in, for example, the area of health information systems for health systems strengthening, the use of low-cost mobile communications for community health worker networking, or in specific applications for communicable or non-communicable diseases, neglected tropical diseases or the diseases of climate change.

Strengthening of health systems

Participants noted that low-cost internet and mobile technologies were now nearing critical mass even in the poorest countries. However, in Africa and the LDCs, unleashing the full power of technology for health in resource poor settings will require a radical rethinking of current approaches. Specifically, it will require a laser-like focus and local analysis on the holistic strengthening of health systems via available and affordable technologies that eschews purely vertical or horizontal strategies. It will require an “all

government” approach that transcends ministerial silos and one that positions digital health at the forefront of national economic and social policy.

As a corollary, it will require the full engagement of business and civil society in a “global partnership for development, particularly with the ICT and pharmaceutical sectors”, as delineated in MDG 8, Targets 17 and 18. The recent move toward a consensus on the importance of health systems strengthening in the global health community was extremely positive but this now had to extend to a common, multi-stakeholder view on how the latter goal could be employed to accelerate scale up – such has been the case with generic drugs. Again, local and national conditions should be taken into account.

Innovation and investment

While participants agreed that the global health landscape was in the path of a tidal wave of change from the digital revolution, the question was posed as to why we were still seeing mostly mere “bubbles of innovation and investment” across the sector? Not only had the case not been made that for every dollar and man hour invested what was the multiplier effect in terms of dollars and lives saved, but duplication of donor or vendor efforts in unsustainable pilot projects, the institutional inertia and general lack of vision of the medical profession vis a vis technology innovation, silos between multiple actors and vertical funding that create digital health silos themselves - all could be cited as root causes.

Was there a panacea? Clearly, mobile health is a fast track solution if applications can be tailored appropriately, but consideration must also be given to promoting broadband communications, the natural medium for multimedia health care applications, at the earliest opportunity. Policy making will also be critical in scaling up with, for example, cross-cutting universal service obligation that bridge the health, technology and development sectors, and innovative financing mechanisms coming from new players now involved in health systems strengthening, such as the Global Fund and GAVI Alliance.

Partnerships in practice

The key question posed to participants was how the rhetoric of public private partnerships (PPPs) had lived up to the reality on the ground? All agreed that, to take full advantage of the opportunities offered by ICT and pharmaceutical advances, it is absolutely necessary for governments, international organizations, civil society and the private sector to work together in a win-win partnership. That meant breaking down the silos that prevent deliverable partnerships for health – silos between governments, silos across ministries, silos among donors, silos between public and private entities, and silos among the United Nations agencies. Digital technologies are also cross-cutting technologies and can be most usefully employed in the interlinked agenda of the MDGs that encompasses poverty and hunger, health and education, and the environment.

But the emphasis from all stakeholders must be on local and linguistically diversified devices and content. Experience has shown from myriad health technology pilots that imported technology not customized or sensitized to local conditions had simply not worked. What was needed now was a “collective partnership model” for digital health in

Africa and the LDCs, clarifying the roles and goals of key partners and new players with strong public sector guidance, most likely fashioned around MDG 8 Target 18, and with a robust set of commonly agreed indicators for measurement and a holistic framework for concrete commitments.

Next steps

At their core, digital health and the democratization of web-based technologies imply tearing down the barriers between north and south, rich and poor, young and old, and private and public. The sheer magnitude of this socio-economic disruption has been part of the problem in getting the message across. Yet, the ground was now ripe to plant new seeds for change. Moving from the anecdotal to the empirical, participants suggested a number of concrete paths forward:

- Map the global digital health landscape;
- Define a sound economic and social metric and model for the strengthening of health systems (and web-based models may already provide the key here);
- Develop innovative financing mechanisms, as they pertain to digital health;
- Advocate a digital health coordinator at the highest level of government for an “all government” approach across health, ICT, finance, planning, education, and other relevant ministries; and
- Articulate a multi-stakeholder partnership platform for digital health, with indicators and commitments most likely based around MDG 8, Target 18.

Focus and coordination working with existing partnerships and around the 2010 time-line and strenuously avoiding overlap and duplication of efforts should be the guiding principle. Ultimately, the problems of access to healthcare in the poorest countries must be viewed through the lens of extreme poverty. There will be no open access to universal health care without access to clean water, sanitation, education and economic empowerment for men and women. Finally, participants looked forward to a continuation of the dialogue at a high level working session on “Digital He@lth and Global Development” planned in New York prior to the United Nations General Assembly on 21 September 2009.

AIDS Vaccines: The Way Forward¹⁴

By the International AIDS Vaccine Initiative (IAVI), the World Health Organization (WHO), the Joint United Nations Programme on AIDS (UNAIDS) and the African AIDS Vaccine Programme (AAVP)

A. Issues paper

Twenty-eight years since the first cases of a novel immunodeficiency disease were reported, the HIV pandemic continues to outpace the global response to it. As of 2007, approximately 33 million people were living with HIV globally and, in that year alone, 2 million people died as a result of HIV-related disease.¹⁵ The pandemic's scale and impacts will undermine the progress of many countries to achieve their MDGs to lower poverty rates, ensure that all children complete primary education, reduce child mortality, improve maternal health, and curb the global tuberculosis epidemic. As such, the global response to AIDS is a key factor in determining whether countries can attain the MDGs and numerous other international goals and commitments in global public health.¹⁶

While significant improvements in HIV prevention and treatment, such as scaling up male circumcision, improving access to HIV testing and counseling for key populations at higher risk of HIV exposure, and more effective treatment regimens have all contributed to slowing the pandemic, only a comprehensive prevention tool kit incorporating HIV vaccines will ultimately end it. Vaccines are consistently among the best and most cost effective tools for fighting infectious diseases, and have historically been the only public health intervention capable of eradicating a disease. Modelling studies have shown that even a 50 per cent effective vaccine, given to just 30 per cent of the population could reduce the number of new HIV infections in the low- and middle-income world by more than half over 15 years; a vaccine that is more effective or reaches a greater number of people would have an even larger impact.¹⁷ With only an estimated 31 per cent of people in low- and middle-income countries requiring treatment now receiving it and an estimated \$8.1 billion USD gap at the end of 2007 in funding required to achieve universal access targets, HIV vaccines would significantly improve the likelihood of attaining the universal access to treatment, care and support goals.¹⁸

To date, the global response to AIDS has committed substantial financial and political resources towards the ultimate goal of developing and delivering an effective HIV vaccine. Investments total approximately \$1 billion USD annually in the ongoing search for HIV vaccines.¹⁹ The results of those investments into both basic and translational researches have been major advances in scientific knowledge and understanding, even when vaccine candidates have not proven successful. Additionally, HIV vaccine research and development, especially in low- and middle-income countries that have participated in clinical research, have generated numerous social, economic and educational benefits, including strengthening the health systems and building research capacity.²⁰ For example, the health and well-being of HIV vaccine study volunteers improved, as a result of their participation; research staff and care givers developed professionally; and communities benefited through enhanced health education and access to health care services. At the

national level, HIV vaccine studies have built scientific capacity, strengthened research institutions, enhanced physical infrastructure, and laid the groundwork for future access to vaccines. And, at the global level, HIV vaccine research has contributed significantly to knowledge in all scientific disciplines, including how to better conduct future studies, especially in low- and middle-income country settings. These efforts have all benefited from the ongoing leadership of UNAIDS and WHO, spawned new champions, such as the Global HIV Vaccine Enterprise and the African AIDS Vaccine Programme, and have served as positive and inspiring examples of how the global community can come together to address common problems.

Recent developments in the HIV vaccine field, in particular the cancellation in 2007 of the STEP and Phambili trials, have redirected the field to a renewed focus on upstream research, with an emphasis on basic and applied research exploring some of the fundamental questions about HIV. Currently, the priorities for the field include: understanding innate immunity, identifying neutralizing antibodies for HIV, and improving animal models for HIV vaccine preclinical testing. Recently, there have been positive milestones in the field, including identification of new and more broadly neutralizing antibodies and the identification of a new generation of replicating vectors that indicate protection in the non-human product model. However, this shift in focus, which comes with an acknowledgment that the likely timeline for an HIV vaccine is longer than many hoped, poses a number of challenges for researchers, advocates, financial supporters and affected communities. Ensuring existing funding streams continue to support cost-intensive basic and applied research and developing new financing mechanisms and sources are perhaps the most urgent priorities for the HIV vaccine field. New strategies to spur innovation in research and development, such as developing new grant programmes, streamlining regulatory processes, assessing the potential for prizes to catalyze novel thinking, and exploring new organizational models for scientific research must all be considered to engage new minds and ideas, especially from the low- and middle-income countries, in answering the HIV conundrum. As well, the existing network of clinical trial centres will have to be maintained while new vaccine candidates are developed. This will ensure this infrastructure and research capacity is preserved and made available for other biomedical HIV prevention modalities and continue to provide local communities with broad-based benefits. Above all, advocacy efforts must be redoubled to effectively communicate to decision makers, policy makers and affected communities that, notwithstanding recent disappointments in HIV vaccine research and development, the global effort to develop HIV vaccines continues to make significant progress and deserves active, sustained support.

In the current economic and fiscal environment, the most immediate and pressing challenge for HIV vaccine research and development, an inherently costly and lengthy undertaking, will be ensuring sustained financial and political support over the long term. Policy makers, in high, low- and middle-income countries must also continue to focus on internationally agreed public health goals that they have signed on to, including eradicating HIV. The way forward in developing HIV vaccines must be premised on equal and active partnership between North and South in science, community mobilization, and civil society engagement to ensure that effort and benefits, both present and future, are truly global.

What are the most effective ways to sustain long-term financial and political support for HIV vaccines to ensure that international public health goals are met?

What are the barriers and/or incentives for governments to prioritize HIV vaccines globally and in their national health agenda?

How can we ensure countries in the South become more active partners, both in research and funding, in the development of HIV vaccines?

B. Summary of discussions

The ministerial roundtable breakfast was held on 8 July 2008. More than 25 representatives from ECOSOC Member States, other delegations, civil society, private sector, United Nations system and other international organizations participated in the event. The roundtable was chaired by Ms. Daisy Mafubelu, Assistant Director-General – World Health Organization (WHO) and representative of WHO/UNAIDS at the Global Vaccine Enterprise Council, and Dr. Tom Mboya, Ambassador of Kenya to the United Nations. The meeting was co-chaired by Ms. Holly Wong, Vice President, Public Policy, International AIDS Vaccine Initiative (IAVI) and Mr. Pontiano Kaleebu, Chairperson of the African AIDS Vaccine Programme (AAVP). The breakfast meeting was moderated by Mr. Paul De Lay, Deputy Executive Director of UNAIDS, the Joint United Nations Programme on HIV/AIDS.

Participants acknowledged that tremendous advances have been made in terms of improved access to affordable treatment options. However, they emphasized that a comprehensive response to the HIV epidemic ultimately has to include an AIDS vaccine. It was noted that we may not meet any of the public health development goals without help from an effective AIDS vaccine. For example, according to UNAIDS estimates, for every two people starting on treatment annually, five new infections occur. A vaccine that is even one-third effective could avert one-quarter of all new infections. The search for a vaccine will be long and complex and will need sustained commitment from a broad range of stakeholders, including people living with, and affected by, HIV, scientists, civil society organizations, policy makers, donors, and private sector partners, including the pharmaceutical and biotech industries.

Participants were further informed about the lessons learnt and the new directions of HIV vaccine research. After the disappointing results of the Merck HIV vaccine trial in 2007, the field has shifted from clinical trials and clinical research to more upstream applied and basic sciences. The goal is to answer several questions that are fundamental to developing a better and more diverse pool of HIV vaccine candidates. The combination of the economic downturn and the disappointing results of recent trials highlight the critical role communities play in particular in calling for political and fiscal support for HIV vaccine research and development (R and D). It was agreed that the road ahead needs to include Africans and African nations more actively in the global effort to develop an AIDS Vaccine. The African AIDS vaccine Programme has to be part of that response to ensure that AIDS vaccine advocacy from the South is coordinated and

representative of the needs of Africans. As Mr. Pontiano Kaleebu noted “There is high quality science going on, capacity is being built, but the regulatory framework is very weak. AAVP wants to ensure that the work being done continues to be of high standard and that funding is sustained in partnership with global partners, such as IAVI.”

Attendees called for:

- long-term support and effective use of existing resources, greater investment in HIV prevention, including research and development, and they further underscored the significance of innovative financing mechanisms to support research for tomorrow;
- the development of a single African drug agency, much like the European medicines agency which regulates the pharmaceutical sector in Europe, especially as Africa lacks stringent quality standards and manufacturing capacity;
- governments and donors to support building the capacity of, and increasing the number of, scientist working towards the development of a vaccine;
- greater involvement and investment from African Member States through the African Union; and
- researchers and funders should explore new, more collaborative, cooperative and transparent approaches to HIV vaccines research and development.

The breakfast meeting concluded with a call to amend the ECOSOC resolution to include HIV vaccines.

Addressing Non-Communicable Diseases and Injuries: Uniting Development and Public Health Agendas²¹

By the World Health Organization (WHO)

A. Issues paper

The issue

Premature deaths from non-communicable diseases (NCDs) and injuries in developing countries are rising at an astonishingly fast rate, with serious implications on poverty reduction and economic growth. Increasingly, policy makers in developing countries are being challenged to formulate evidence-based public policies and plans to prevent premature deaths from NCDs and injuries, thereby addressing one of the key public health and development challenges of the 21st century.

- NCDs and injuries are serious threats to the health and lives of people in developing countries: NCDs and injuries account for 70 per cent of deaths worldwide, and 80 per cent of these deaths occur in developing countries. Some 60 per cent of all deaths globally are due to the four main NCDs: cardiovascular diseases, diabetes, cancers and chronic respiratory diseases. An additional 10 per cent of deaths globally are due to injuries, mainly road traffic crashes, burns, falls, other types of unintentional injury, violence and suicide.
- NCDs and injuries are serious threats to socio-economic development: The World Economic Forum's survey of global risks for 2009 ranked NCDs as the third most likely risk to come true and the fourth most severe in its impact. NCDs were seen as threats to global well-being, exceeded only by asset price collapse, spikes in oil and gas prices, and the slowing of the Chinese economy. Similarly, WHO estimates that heart disease, stroke and diabetes alone are estimated to reduce GDP between 1 to 5 per cent per year in developing countries experiencing rapid economic growth. The World Bank estimates that one-third of the poorest two quintiles in developing countries die prematurely from NCDs, which affect their families and act as a chronic poverty trap for them. The cost of lifelong treatment drains household incomes and catastrophic health care expenditures push many households into poverty.
- In addition, there is a significant economic loss from injury, both from treatment costs, as well as lost wages and economic productivity. These costs are especially severe, as many of those injured are working-aged adults. In developing countries, the economic cost of road traffic injuries alone has been estimated at nearly US\$100 billion, which is twice the sum of all official development assistance. Most countries lose 1 – 2 per cent of their GDP in injury-related consequences from road traffic crashes.

- The epidemic of NCDs and injuries is the product of failed development: of unhealthy urbanization, of poor trade and policy choices and of health systems unprepared for those most in need of care. A fundamental economic and development choice is thus facing the world today.
- Today, key instruments to promote sustainable human development, such as the MDGs, as well as poverty alleviation strategies, do not include mechanisms to incorporate the prevention and control of NCDs and injuries. International aid and development agencies are “missing in action” in relation to NCDs and injury prevention and control. They are virtually absent in terms of providing technical support to developing countries in building sustainable institutional capacities to address NCDs and injuries and mitigating the negative impact on socio-economic development.

Affordable solutions exist

NCDs and injuries are largely preventable. Affordable solutions exist to avoid premature deaths from NCDs and injuries. Reviews of international experience in the prevention and control of NCDs and injuries, including community-based programmes, have been conducted, and lessons learnt have been identified and disseminated.

Between 40-50 per cent of heart disease, stroke and type-2 diabetes are premature and could, in large part, be prevented by eliminating tobacco use, promoting healthy diets, increasing physical activity and reducing the harmful use of alcohol. One-third of cancers can be prevented and another third can be cured, if detected early. Similarly, an established set of interventions based on the best science available has also been identified to significantly reduce the impact and incidence of road traffic injuries. While more research is needed to strengthen the evidence base of affordable solutions, successful approaches for intersectoral action against NCDs and injuries include:

- tobacco taxation policies; smoke-free policies; tobacco advertising and promotion bans; health warnings on tobacco packages; assistance with quitting; fruit and vegetable promotion; physical activity promotion; population-based salt reduction efforts; road safety laws against speeding and impaired driving; mandatory motorcycle helmet laws; secondary prevention of cardiovascular diseases; early detection and treatment of breast and cervical cancers, diabetes, hypertension and other cardiovascular risk factors; and trauma and emergency care services.

These interventions can be delivered through public policies, including through settings-based approaches in schools, workplaces and communities, as well as through approaches in clinical settings, with special focus on primary health care.

The way forward

A number of recommendations were offered by the ECOSOC/UNESCWA/WHO Western Asia Ministerial Meeting “Addressing NCDs and injuries: major challenges to sustainable development in the 21st century” (hosted in Doha by the Government of Qatar, 10-11 May 2009) for consideration by the Economic and Social Council, including:

- Integrate evidence-based indicators on NCDs and injuries into the core MDGs monitoring and evaluation system during the upcoming MDGs Review Summit in 2010;
- Include the issue of NCDs and injuries preventions in the ECOSOC 2010 coordination segment and other global discussions on development;
- Raise the priority accorded to NCDs and injuries preventions on the agendas of relevant high-level forums and meetings of national, regional, and international leaders;
- Review international experience in the prevention and control of NCDs and injuries in developing countries, including community-based programmes, and identify and disseminate successful approaches for intersectoral action;
- Develop and disseminate tools that enable public policy decision makers to assess the impact of policies on the determinants of risk factors for, and consequences of, NCDs and injuries and provide models of effective evidence-based policy making;
- Strengthen the standardized data collection on NCDs and injuries and establish baselines, with special emphasis on strengthening data on the socio-economic impact, including poverty at the household level;
- Collaborate closely with, and provide support to, developing countries and the WHO in implementing the various components of the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of NCDs endorsed by the World Health Assembly in May 2008.

Working in partnership

Providing effective public health responses to the global threat posed by NCDs and injuries requires strong international partnerships. The building and coordinating of results-oriented collaborative networks are essential components of a global strategy. Networks are also vital because resources for the prevention and control of NCDs and injuries are limited in most national and intergovernmental budgets. Collaborative work should be fostered among United Nations agencies, other intergovernmental institutions, bilateral donors, philanthropic foundations, academia, research centres, NGOs, mass media and the private sector.

B. Summary of discussions

The ministerial roundtable breakfast, which was held on 8 July, was co-chaired by H.E. Ms. Sylvie Lucas, President of ECOSOC, and Dr. Ala Alawan, Assistant Director-General of WHO.

In all developing countries, and by any metric, non-communicable diseases (cardiovascular diseases, cancers, diabetes, chronic respiratory diseases) and injuries (caused by traffic crashes, burns, falls, drowning or violence) now account for a large enough share of preventable deaths and disability among the poor to merit a concerted and coordinated policy response. Public policy makers in developing countries are

increasingly challenged to formulate effective strategies to address NCDs and injuries and links to poverty. However, requests for technical support from developing countries remain unanswered by the international community because these problems are beyond those targeted by the MDGs. Discussions at the ECOSOC Ministerial Roundtable Breakfast on Non-communicable Diseases and Injuries (Geneva, 8 July 2009) provided an opportunity to discuss this impasse and to propose solutions to move forward.

The participants first examined the magnitude of NCDs and injuries in developing countries and its socio-economic impact at macro-economic and household levels. A consensus emerged around the following two perspectives:

The public health perspective

While death is inevitable, it should be neither premature nor preceded by years of poor health. Every year, an estimated 8.0 - 13.7 million lives can be saved in 144 developing countries eligible for ODA by preventing premature deaths from NCDs through (i) reducing the level of exposure of individuals and populations to tobacco use, unhealthy diets, physical inactivity and the harmful use of alcohol; and (ii) strengthening primary health care to enable services to respond more effectively and equitably to the health-care needs of people with NCDs. In addition, more than 5 million lives can be saved each year in developing countries by preventing injuries through promoting road safety and enforcing road safety legislation to make roads safe for pedestrians, cyclists and motorcyclists, promoting injury and violence preventions, and strengthening trauma and emergency care services. Millions more could be prevented from becoming disabled by NCDs and injuries.

The development perspective

Heart disease, stroke and diabetes alone are estimated to reduce GDP between 1 to 5 per cent in developing countries experiencing rapid economic growth, as many people in these countries die younger from NCDs, often in their most productive years. Similarly, most developing countries lose 1 to 2 per cent of their GDP in injury-related consequences from road traffic crashes. Sufficient evidence is also emerging to prove that NCDs and injuries contribute to poverty at a household level. The poorest households often spend more than 10 per cent of their income on tobacco. The cost of caring for a family member with diabetes can be more than 20 per cent of low-income household incomes in developing countries, until households are impoverished by the cost of care and can no longer afford these health care services. Over 70 per cent of households report declines in income after the death of a family member from a road traffic crash.

In the course of the discussions, the serious omission of NCDs and injuries from the MDGs was highlighted. Consensus over the lack of a common position among international development cooperation agencies to include NCDs and injuries in global discussions on development -- because these problems are beyond those targeted by the MDGs -- were balanced with optimism that proposals to move forward exist: many require the active involvement of the permanent missions in New York at the upcoming 64th Session of the United Nations General Assembly starting in September 2009. The following views emerged:

The donor country's perspective

There is a lack of a common position among international development cooperation agencies on the necessity of including NCDs and injuries in global discussions on development. To date, only AusAID and NZAID have provided bilateral and multilateral support to address NCDs and injuries. The World Bank has also started to provide limited support to this area. Other donor countries are largely absent in this area.

The partner country's perspective

Developing countries face problems beyond those targeted by the MDGs. One-third of the poorest people die prematurely from preventable NCDs and injuries, which are not included in the MDGs. NCDs and injuries must, therefore, also be addressed if the overarching goal of the MDGs to put and end to poverty in 2015 is to be achieved. Policy makers in developing countries have pledged to address NCDs and injuries at many international forums. But, unfortunately, less than 1 per cent of ODA is allocated by donors and international agencies to these areas. In May 2008, donor and partner country governments unanimously endorsed a call for action at the World Health Assembly to raise the priority accorded NCDs in development work at global and national levels. This call was included in the Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases. Donor countries and international agencies can, therefore, no longer afford to remain a bystander and "missing in action" and must start to respond to requests from developing countries to provide bilateral and multilateral support aimed at strengthening national capacities in these areas.

During the interactive discussion that followed, the challenge to urgently identify proposals to overcome the current impasse and move forward was stressed. The many lessons learned in relation to including HIV/AIDS in global discussions on development, which are highly applicable to NCDs and injuries, were highlighted. Proposals to move forward included: continuing the discussions at the 64th regular session of the United Nations General Assembly; convening a special international conference under the patronage of the United Nations Secretary-General or a special session of the United Nations General Assembly devoted to NCDs and injuries; requesting adding indicators on deaths from non-communicable diseases and injuries under 'MDG 6: Combat HIV/AIDS, malaria and other diseases' during the MDG 2010 Review Summit; including an agenda item on this topic during the ECOSOC 2010 coordination segment; encouraging regional intergovernmental organizations to prioritize NCDs and injuries; and establishing regional multisectoral task forces on addressing NCDs and injuries in developing countries.

The Implications of Population Ageing for Global Public Health²²

By the Population Division of the Department of Economic and Social Affairs of the United Nations

A. Issues paper

The world population is ageing and the process leading to increasing proportions of older people depends on both the reduction of fertility and the reduction of mortality that is, in turn, associated with a major change in the causes of disease and death in a population. Infectious and parasitic diseases are major causes of sickness and death in countries where mortality remains high, whereas in those where ageing is accelerating, the major proportion of deaths is caused by non-communicable diseases. Population ageing is, therefore, closely intertwined with major changes in the burden of disease and demands changes in public health interventions and the provision of healthcare to ensure that older populations reap the benefits of healthy ageing.

The Commission on Population and Development, as the intergovernmental body in charge of monitoring the implementation of the Programme of Action adopted in 1994 by the International Conference on Population and Development held in Cairo, has been focusing on the health aspects of population dynamics in addressing its annual special themes. In 2007, the Commission focused on the changing population age structures and their impact on development and, this year, it focused on the contributions of population dynamics to the attainment of the MDGs. The work of the Commission has helped elucidate the implications of population ageing for global public health.

Population ageing is more advanced in the developed world, where the population aged 60 or over already accounts for 22 per cent of the overall population and will likely account for about 33 per cent of the population in 2050. Today, the number of older persons in developed countries already surpasses the number of children under age 15. Although population ageing is less advanced in developing countries, their population is projected to age faster than that of developed countries in the past. Today, persons aged 60 or over already account for 9 per cent of the population of the developing world and will likely constitute 20 per cent of their population by mid-century. Globally, the number of persons aged 60 or over is expected almost to triple, increasing from 739 million in 2009 to 2 billion by 2050, and today, 65 per cent of the world's older persons live in developing countries.

Within the developing world, ageing is not proceeding at the same pace everywhere. The population of the least developed countries, in particular, remains young, with scarcely 5 per cent of their inhabitants are aged 60 or over. The rest of the developing world and particularly some of the most populous middle-income countries are ageing rapidly. Already 9 per cent of their inhabitants are aged 60 or over and that proportion will likely reach 23 per cent by 2050.

Population ageing is the result of declining birth rates and increasing longevity. Today, populations that still have high fertility are also characterized by relatively high child mortality and high prevalence of infectious and parasitic diseases. The impressive reductions in mortality that have been experienced by most developing countries since 1950 have been made possible by improved methods to control or cure those communicable diseases. Health systems, particularly in today's middle - income countries, expanded at a time when the major causes of death were communicable diseases and are still not well adapted to cope with the types of chronic and degenerative diseases common in ageing populations.

According to data compiled by the World Health Organization, in today's developed countries, the majority of deaths, 86 per cent, are caused by non-communicable diseases whereas the group constituted by communicable diseases, maternal and perinatal conditions account for just 6 per cent of all mortality, and external causes (including injuries due to accidents, homicides and suicides) account for a further 8 per cent. In the least developed countries, in contrast, communicable diseases, maternal and perinatal conditions account for 63 per cent of all deaths, whereas non-communicable diseases account for just 30 per cent. The situations in the least developed countries and that in developed countries illustrate the beginning and end stages of what is known as the epidemiological transition, that is, the process whereby mortality declines because of a reduction in the incidence of infectious and parasitic diseases and the deaths they would have caused brought about by a variety of public health interventions (better hygiene, access to safe drinking water and sanitation, control of disease vectors, prevention of food contamination, etc.) and improved access to preventive and curative medicines, including vaccines. Success in controlling communicable diseases translates in greater longevity and leads to a different profile in the burden of disease, with NCDs becoming more common and accounting for an increasing proportion of deaths than those caused by communicable pathogens. The developed world has reached the end stage of that transition.

The process of population ageing has been inextricably linked to the epidemiological transition and, despite the emergence of HIV/AIDS, the majority of the developing countries, excluding most of the least developed countries, exhibit today an intermediate stage in the transition. Thus, the proportion of deaths caused by NCDs in those developing countries is already nearly double that of the deaths caused by communicable diseases (59 per cent vs. 30 per cent) and their health systems are having trouble providing the necessary care, treatment and services to a growing number of people living with chronic or degenerative diseases. In addition, there is a growing concern about changes in lifestyles that are detrimental to health, especially in the middle-income countries. Rising tobacco use, unhealthy diets and lack of exercise are contributing to increase the prevalence of cardio-vascular disease and some cancers. Both the public health measures need to reverse these trends and the changes in health systems that have to be implemented are urgent, if the human and economic costs associated with new disease burdens are to be moderated.

Participants in the roundtable breakfast are requested to be ready to discuss the experiences of their countries in adapting to the changes associated with population ageing, including those relative to the reform or strengthening of health systems, changes

in the training of health personnel, the development and implementation of public health measures to prevent or reduce the prevalence of chronic disease, measures to improve access to drugs and insurance or support schemes to ensure that the poor have access to a basic package of health care.

B. Summary of discussions

The Ministerial roundtable breakfast was held on 8 July 2009, and was co-chaired by H.E. Mr. Ronny Leshno-Yaar, Permanent Representative of Israel to the United Nations in Geneva, and H.E. Ms. Mabel Gómez Oliver, Deputy Permanent Representative of Mexico to the United Nations in Geneva. They represented the Member States that currently held the chair of the Commission on Population and Development (Israel) and that had chaired the forty-second session of the Commission (Mexico) earlier in 2009. The purpose of the roundtable was to bring to the attention of delegates attending the 2009 session of ECOSOC the relevance of the work of the Commission on Population and Development for global public health.

Participants noted that the population of all countries was ageing, and that there were already more older people in the less developed regions than in the more developed regions. It was recognized that ageing was mainly a result of decreasing fertility, but that it had been preceded and accompanied by major reductions in mortality, driven by a falling prevalence of communicable diseases and more effective ways to treat them. As communicable diseases claimed fewer lives, NCDs have gained ground. Currently, the higher the share of non-communicable diseases in a country, the lower the overall mortality: in high-income countries, where life expectancy is above 76 years, non-communicable diseases account for 86 per cent of all deaths, whereas in low-income and middle-income countries, where average life expectancy is still below 65 years, those diseases account for 44 per cent of all deaths.

The exchange of views revealed the various expressions of these processes in different countries and the range of institutional and policy responses undertaken. For example, the population of Mexico is ageing rapidly; so much so that by mid-century, it could attain an age distribution similar to that of European countries today. The decline in mortality there has paralleled the increase in the share of deaths caused by non-communicable diseases, which currently account for 73 per cent of all deaths. Diabetes, cardio-vascular disease and obstructive lung disease are currently major killers of older people. The elderly also suffer from a high prevalence of disability affecting mobility, eyesight and hearing. Although Mexico's health system is not yet ready to provide all the needed services and care needed for the older population, there are significant initiatives in place, such as the 2007-2012 National Health Programme and the Institutional Gerontology Plan, 2006-2025, which promote healthy and active ageing, as well as "ageing at home". The Government is also expanding health insurance coverage through the People's Insurance System, establishing specialized public hospitals, expanding access to basic drugs, and increasing the number and improving the skills of health personnel.

A different example is that of Israel, whose population is more aged than Mexico but still young to most developed countries: persons aged 65 or over account for just about 10 per cent of the population. Because of the importance of the traditional family, most older

persons live at home, and the Government has endeavoured to provide the needed care within the community. Older persons in Israel receive income support in the form of old age allowances or a minimum guaranteed pension, and additional benefits to low-income families with older persons. The Government provides universal health coverage, with rehabilitation services included, and hospitals have special geriatric wards. Nevertheless, public policies emphasize the expansion and strengthening of home health care services, including day care visits for older persons, the provision of portable medical equipment for use at home, friendly home visits by volunteers, and the maintenance of social ties. The system is also mindful of the need to support caregivers, most of whom are women. Israel is working with WHO to share its experiences and assist other countries, for instance, Mexico, in developing a well coordinated support system for older persons to cope with illness and disability within the family and the community.

The situation is very different in other developing countries, which have younger population age structures, and less developed institutions to deal with the consequences of ageing. In Kenya, for instance, with a proportion of the population aged 60 years or over of the order of 4 per cent, older persons are not yet a major priority of government policy. However, some initial steps have been taken, for example, the establishment of an advisory board on population ageing. The board has found evidence from household surveys that households with an older person are more likely to be poor and suffer from malnutrition. Because of the high prevalence of HIV/AIDS, mortality among persons aged 15 to 49 is high, and older persons often have to serve as caregivers of those affected by the disease or of their orphaned children. Also, a recent survey suggests that health workers in rural areas tend to discriminate against older people in the provision of services. All of these issues must be addressed early on in a forthright manner.

The prevalence of chronic and non-communicable diseases that affect all adults and older persons, in particular, has increased especially rapidly in medium-income countries. One case in point is that of Barbados, where a National Commission on Non-Communicable Diseases has been established, whose objective was to reduce the incidence of such diseases and improving their management from the health and social perspectives. Sharing the experiences of Mexico, Israel and other countries could be very useful in tackling these issues in a more systemic fashion. In effect, the Government of Barbados is seeking ways to foster international partnerships to respond to the challenges posed by NCDs. Some participants indicated that to increase the visibility of the impact of such diseases at the international level, the topic should be taken up during the coordination segment of ECOSOC in 2010, which would continue the consideration of global public health. Other possibilities would be given to hold a high-level meeting or a special session of the General Assembly, focusing specifically on NCDs, and, given that these diseases account for the majority of deaths in developing countries, to consider developing indicators relative to NCDs in the MDG framework.

Participants noted that NCDs are also highly prevalent in the more aged developed countries, although in different cultural, health and policy contexts. For example, in Japan, the most aged country in the world, there is a long tradition of celebrating ageing as a success and older persons were the object of great respect. Perhaps for that reason, Japanese society seemed to be adapting well to an ageing population. Since it has been demonstrated that many NCDs have their origin in life-style choices harmful to health,

such as tobacco use, unhealthy diets or lack of exercise, the interventions to change life styles or prevent the adoption of unhealthy life styles are essential. This implies that improving the health of older population should start with the young because a lifetime of exposure to unhealthy life styles leads to disease and disability in old age.

Participants agreed that respect and due attention to the health needs of older persons should be promoted in all societies and underscored the importance of international cooperation, where expertise was shared and practical ways of improving the health of ageing populations were implemented. They also noted that the discussions held during this roundtable breakfast were a good preview for the forty-third session of the Commission on Population and Development that would focus in 2010 on the special theme of “health, morbidity, mortality and development”.

Promoting Migrant Women Health Needs into MDGs-The Case of Violence against Women and Girls²³

By the International Office for Migration (IOM), the Office of the Special Advisor on Gender Issues (OSAGI) and the World Health Organization (WHO)

A. Issues paper

Background

About half of all migrants are now women, with more women migrating independently and as main income- earners rather than accompanying male relatives. Migration can provide a vital source of income for migrant women and their families, and earn them increased autonomy, self confidence and social status. Yet, female migrants can be doubly exposed to exploitation as migrants and as women.²⁴

Migration itself is not a risk to health but the circumstances under which people migrate, the conditions in which they move into receiving societies and the legal context surrounding their move can increase vulnerability to ill health, including violence. This is particularly true for those who are forced to migrate, fleeing natural or man made disasters, human rights violations, economic crises and unemployment, or for migrants who find themselves in an irregular situation. Women migrants face multiple vulnerabilities and risk gender-based discrimination and violence at all stages of the migration process.

The Millennium Development Goals (MDGs) have been described as an important way to ensure that globalization benefits are evenly spread and shared. However, their outcomes, to date, are a testimony of the many inequalities within countries, within regions and between the sexes. Progress has been uneven not only between countries but also between populations within countries and regions. For instance, poor and marginalized populations do not see the same reductions in child mortality and maternal mortality as richer populations. Certain migrant populations remain outside a health and social service delivery system and form part of those populations for whom the MDGs have not implied enough progress. Vulnerabilities of migrant women to all kinds of violence illustrate this concern of unequal achievement of the internationally agreed goals.

Health is influenced by policies of other domains and health has, in turn, important effects on the realization of the goals of other sectors. Health of women is additionally influenced by dominant social and cultural models and values or conditions of coercion that might determine their capacity to access needed services. An open, constructive and affirmative multi-sectoral dialogue based on shared and fundamental societal values, such as solidarity, integration and human rights, as well as sound public health and primary health principles, can contribute to improving health outcomes for migrants, including the

most marginalized, and their host communities and address more equal distribution of the MDGs.

Women's vulnerability to violence during the migration process

In the context of complex emergencies and natural disasters, displaced women and children are disproportionately affected by physical and sexual violence, abuse and intimate partner domestic violence because they are separated from (part of) their family members and communities, which weakens community support systems and protection mechanisms. In addition, existing social structures and institutions that usually can offer protection are often destroyed or function less than optimally. Existing laws may not be enforced. Survival sex may become the only alternative for some.²⁵

Health risks in migrant hosting communities are often linked to the legal status of migrants, as it determines their level of access to social services and freedom to seek help when needed. Further factors potentially determining health status in hosting communities include poverty, stigma and discrimination, social exclusion, differences in language and culture, and separation from family and socio-cultural norms. Scarce data show that lack of legal status, increases irregular migrant women's risk to violence and sexual assault, and reduces their access to protection, care, including reproductive health care. This is particularly worrying, given that irregular migrant women are more likely to experience unwanted pregnancies than other women due to lack of access to family planning services and education, as well as the result of sexual violence. Even if reproductive health services are available, many may not access them out of fear for deportation or because they are not available in culturally or linguistically appropriate ways.²⁶

Trafficked populations form a particularly vulnerable group amongst the migrants in an irregular situation. To date, there is limited research-based data on the health of trafficked persons. Most existing evidence on health is based on individuals attending post-trafficking services, and primarily applies to women and girls trafficked for sexual exploitation.²⁷ The rare studies available indicate that vast majority suffer violence, physical and or sexual, during the trafficking process.

In the midst of the global economic crisis, with rising rates of unemployment, the situation of migrant workers is under threat. Those in the weakest position, such as women workers and particularly those undocumented are so desperate that they are forced to accept almost any condition to hold on to their jobs, despite unsafe conditions, abuse, and risk of sexual exploitation without access to social services and legal protection. A joint initiative of UNDP, UNAIDS, IOM and UNIFEM documented the exposure of migrant women to abuse, including sexual exploitation and increased vulnerability to HIV.²⁸

Making migration safe: messages for policy makers

Achieving health-related MDGs effectively will, among other factors, requires the empowerment of women and equal access to health services to marginalized populations, such as certain migrant groups and, in particular, to migrant women. This is not the reality today.

As migration is a fact of life, a vital challenge facing governments is to integrate the health needs of women and men migrants into relevant policies of all relevant sectors, well beyond the health sector only, in order to work towards inclusive approaches that can lead to improved health for societies and contribute to their stability and development. The particular vulnerabilities of migrant women throughout the migration process to different kinds of violence, and the potential barriers to accessing health and other relevant social services, must be included in local, national and international policies and responses, in order to render migration safer. In that respect, host and home countries and communities have an equal responsibility to provide protective policies and programmes. In addition, those providing protection and humanitarian assistance in case of crises situations need to integrate responses to violence against women into their relief efforts.

Health systems need to take into account the multi-ethnic and multi-cultural characteristics of today's countries and communities due to globalization and crises. Migration-hosting communities the world over need to provide accessible, acceptable and affordable health services, as a cornerstone of primary health care and a basic right to all migrant populations, irrespective of their legal status.

Issues for consideration

- Do core values of primary health care, such as promoting universal access in support of equity and extending the right to health into other policy areas offer a rapid progress towards the MDGs for all?
- Have countries/organizations identified best practices to better mainstream gender considerations, including violence against women, into migration and development policy, legislation and programming?
- How can civil society associations and migrant communities be more involved in the design, implementation and evaluation of programmes and interventions in the domain of migrant health, in general, and in the domain of violence against women, in particular?
- What are capacity-building needs for health professionals and policy makers regarding addressing the health and vulnerabilities of marginalized migrant groups?
- How can the socio-economic determinants of the health of migrants (including labour, housing conditions, and access to social services) be better addressed and what is the role of the health sector in this regard?
- How is it that health, as a recognized contributor to economic and social development, is absent at major global and regional dialogues on migration and development (e.g. GFMD, Colombo Process and other labour migration dialogues)?

B. Summary of discussions

The ministerial roundtable breakfast took place on 9 July 2009, and was co-chaired by Ms. Rachel Mayanja, Special Adviser on Gender Issues and Advancement of Women, Office of the Special Adviser on Gender Issues, Dr. Daniel Lopez Acuna, Director,

Recovery and Transition Programmes, Health Action in Crisis, the World Health Organization, and Ms. Ndioro Ndiaye, Deputy Director-General, International Organization for Migration.

The discussions began with the highlighting of the fact that half of all migrants are women and many migrate independently and as main income earners. Although migration itself is not a risk to health, the circumstances surrounding the migration process can increase vulnerability to ill health, including violence. This is particularly true for those who are forced to migrate or for migrants who find themselves in an irregular situation. Women migrants face multiple vulnerabilities and risk gender-based discrimination and violence at all stages of the migration process. Ms. Mayanja further stressed the unequal achievement of the MDGs and that the MDGs have not implied enough progress for many migrant groups, who fall outside health and social delivery mechanisms. Because health is influenced by policies of other domains, she called for a multi-sectoral dialogue to determine key recommendations and action plans to contribute to improved health outcomes for migrants, in particular, women.

In addition, mention was made of IOM's efforts to address migrant health in the context of crisis, including emergency situations, and the agency's concerns about the possible impact of the financial crisis on migrants. Both WHO's Migrant Health Resolution and the UNAIDS PCB Thematic Session People on the Move were welcomed as positive measures in the right direction. Also mentioned was the launching of the IOM publication "Caring for trafficked persons: Guidance for health providers", which was jointly written with several partners and aims to contribute to the need for guidance on managing migrant health matters.

It was pointed out that migration is not gender-neutral and women face different and multiple challenges compared to men. Also emphasized was the particularly precarious situation of undocumented migrant women who tend to lack access to health services, including pregnant women. In addition, it was recalled that many migrant women are caregivers and leave their families, including children, behind, leaving them in possibly vulnerable situations as well.

Participants raised a great variety of determinants, concerns and vulnerabilities, as well as desired approaches and good practices in the domain of migrant women's health. Migrant trends in relation to societal processes were described, as well as how migration flows have diversified and increased over time. Some countries that used to be sending countries are now also receiving migrants. All participants who spoke agreed that migrants suffer increased health vulnerabilities, and that addressing the health of migrants is necessary and is also a matter of social justice and human rights. Health access should apply to migrants irrespective of their legal status and be specially attuned to the needs of migrant women.

Major obstacles or threats to migrant women's health that were mentioned by multiple participants included: legal status, as the undocumented have limited or no access or fear deportation when seeking care; exploitation; discrimination; low wages; emergencies, especially conflict, and related sexual, physical violence, cultural, as well as psychological violence and pressures. It was noted that the financial crisis is creating

additional obstacles to health access and is increasing risks due to, for example, lack of job opportunities.

While the health consequences related to migration and being a woman migrant can be wide ranging, specifically mentioned were reproductive health, mental and psychosocial health, infectious problems (such as tuberculosis), as well as certain non-communicable problems. Participants pointed out that the context of pandemic threats requires special attention for migrants' health though, too often, migrants are only considered as potential vectors of disease.

In terms of approaches to address migrant health and improve health status of migrants, some mentioned universal access to health for all migrants in their country. However, there can be certain administrative requirements before migrants, including the undocumented, can access services (e.g. proof of minimum length of stay). There was also mention that easy access for migrants to health services has been a trigger for some to migrate, in order to make use of services unavailable at the home community.

Migrant participation in developing approaches was reported as essential to ensure migrants will, indeed, access services and that services are “migrant friendly”. Related to this, the need for capacity building of the health workforce in terms of delivering migrant-friendly services adapted to the cultural, including gender specific matters, and language of migrants, was highlighted. In addition, capacity building was mentioned in the context of addressing the different health profiles of migrants, as compared to host communities' health profile.

It was noted that while non-governmental efforts to assist migrants are good and important, governments should take ownership in meeting the health needs of migrants and avoid parallel health service mechanisms for the marginalized. Countries should work towards services that are inclusive and accessible for all and migrant health should find a venue within governments.

While recognizing the difficulties, there is a need for more studies to document migrants' health and related determinants, in order to develop more scientific approaches and more sensitive programs to include hidden vulnerable groups of migrants. The importance of cross-border surveillance mechanisms was stressed, in order to control spread of disease as well as manage infectious problems among mobile populations.

Important upcoming events and processes that were highlighted included the “EU-Level Consultation on Migration Health – Better Health for All”, Lisbon, September 2009; the “International Conference on Violence Against Women”, Rome September 2009; the “Global Forum on Migration and Development” (GFMD) in Athens, November 2009, which, unfortunately, does not yet include health in its agenda; and the “Foreign Policy and Global Health Resolution”, mentioned as an important process that, so far, does not address migration and human mobility, other than mobility of health workers. Besides global events, such as the GFMD, and regional platforms on migration as well as health, the need to develop mechanisms to ensure action on migrant health at country level was noted.

The important leadership of Portugal in bringing migrant health to the international agenda during its EU presidency was acknowledged. Portugal's efforts had been essential

in bringing the topic to the World Health Assembly (WHA) in 2008, at which time the WHO Resolution on Migrant Health was adopted.

The discussion concluded with the acknowledgement that there is clearly a feminization of migration and that migration affects all countries and is a reflection of economic and political processes in the world today. Migration health is an intersectorial issue that requires actions within various domains, such as the context of Social Determinants of Health, and Foreign Policy. Governments were called on to address migrant health at the national as well as regional level. It was noted that, during the next WHA Assembly, the WHO secretariat would report on the progress made with respect to the migrant health resolution and aims at convening a global consultation to address effective regional and country practices, working with partners such as IOM and other actors in this domain. Furthermore, it was reiterated that the health needs of migrants require services adapted to the special needs, health profiles, culture and language of migrants, which implies increased capacity of health service providers. Especially emphasized was the fact that violence is not only associated with conflicts but part of the realities in many societies and especially affecting many migrant women during all phases of the migration process.

Recommendations and action points

The following recommendations and action points, to be implemented in the near future, were identified during the debate as necessary to work towards a more equal distribution of the MDGs and to include migrant women's health needs higher on the international agenda:

- Governments should commit to include health and the particular health needs of women in the GFMD discussions. Including health into the Mexico GFMD in 2010 should be a realistic target;
- The Foreign Policy and Global Health Resolution, proposed to be brought to the 64th session of the General Assembly, ought to address migration and human mobility as a topic cutting across relevant policies implied in the vast domain of foreign policy and global health;
- Capacity building of the public health workforce should increasingly address cultural competence issues and health issues associated with human mobility;
- Health system strengthening and related primary health care reform should integrate migrant health needs and acknowledge the needs of migrants as a potentially marginalized group in society;
- Social determinants of health and the recommendations of the Commission on the Social Determinants of Health should be a vehicle to address migrant health needs; and,
- Calls for partnership among agencies and countries should be put into practice through concrete mechanisms, such as the WHA Resolution on Migrant Health.

Notes

- 1 From the ministerial roundtable breakfast, “Global Public Health – High-quality, low-cost pharmaceutical production in developing countries”, 7 July 2009.
- 2 WHO and Health Action International (HAI), “Measuring medicine prices, availability, affordability and price components”, 2. edition, 2008, p. 1. Access to medicines plays an important role in the realization of the UN MDGs, see Goal 6 (Combat HIV/AIDS, malaria and other diseases), and Goal 8, target 17 (In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries);
See http://www.who.int/mdg/goals/041222health_mdgchart_en.pdf.
- 3 This is the view expressed by the former CEO of Merck, see “Public health, innovation and intellectual property rights”, Report of the World Health Organization’s Commission on Intellectual Property Rights, Innovation and Public Health (CIPRH), Geneva, April 2006 [hereinafter CIPRH Report], p. 131/132.
- 4 Resolution WHA 61.21 op. 31
- 5 Resolution WHA 61.21 op. 33
- 6 See OECD, 21 June 2007: Noordwijk Medicines Agenda, <http://www.oecd.org/dataoecd/62/11/38845838.pdf>.
- 7 See No. 3 and 4 of the Resolution P6_TA-PROV (2007) 0353 of 12 July 2007; <http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-//EP//TEXT+TA+P6-TA-2007-0353+0+DOC+XML+V0//EN>.
- 8 From the ministerial roundtable breakfast, “Accelerating efforts to save lives of women and newborns”, 7 July 2009.
- 9 UNAIDS, UNFPA, UNICEF, WHO, World Bank, Bill & Melinda Gates Foundation, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Global Alliance for Vaccines and Immunization (GAVI).
- 10 From the ministerial roundtable breakfast, “Digital health and development in Africa and the LDCs: Role of Public and Private”, 7 July 2009.
- 11 In cooperation with the Office of the Special Advisor on Africa (OSAA), Office of the President of the 63rd Session of the General Assembly (OPGA), United Nations Office for Partnerships (UNOP), World Health Organization (WHO), Global Health Workforce Alliance (GHWA), United Nations Environmental Programme (UNEP), United Nations Development Programme (UNDP), World Food Programme (WFP), United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), UNAIDS, International Telecommunication Union (ITU), International Labour Organization (ILO), Department of Economic and Social Affairs (DESA), United Nations Educational, Scientific & Cultural Organization (UNESCO), United Nations Conference on Trade & Development (UNCTAD), United Nations Human Settlements Programme (UN-Habitat).
- 12 In cooperation with Millennium Campaign, Millennium Promise, The Earth Institute at Columbia University, The Rockefeller Foundation, Commonwealth Business Council, African Business Roundtable, United Nations Foundation, Vodafone Group Foundation, Global Business Coalition on HIV/AIDS, Tuberculosis and Malaria, Global Information Infrastructure Commission, Global Alliance for Improved Nutrition, International AIDS Vaccine Initiative, African Medical and Research

- Foundation, International Business Leaders Forum, Oxford Health Alliance, Scientists Without Borders.
- 13 See Achieving the Millennium Development Goals in Africa – Recommendations of the MDG Africa Steering Group, June 2008.
 - 14 From the ministerial roundtable breakfast, “AIDS vaccines: the way forward”, 8 July 2009.
 - 15 UNAIDS. Report on the Global AIDS Epidemic. Mexico City, August 2008
 - 16 Ibid.
 - 17 International AIDS Vaccine Initiative. Estimating the Impact of an AIDS Vaccine in Developing Countries. New York, 2006
 - 18 World Health Organization. Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector. Geneva, June 2008
 - 19 HIV Vaccines and Microbicides Resource Tracking Working Group. Sustaining the HIV Prevention Research Agenda: Funding for Research and Development of HIV Vaccines, Microbicides and Other Prevention Technologies . New York, 2008.
 - 20 AIDS Vaccine Advocacy Coalition. AIDS Vaccine Trials - Getting the Global House in Order. New York, 2004.
 - 21 From the ministerial roundtable breakfast, “Addressing non-communicable diseases and injuries: uniting development and public health agendas”, 8 July 2009.
 - 22 From the ministerial roundtable breakfast, “The implications of population ageing for global public health”, 8 July 2009.
 - 23 From the ministerial roundtable breakfast, “Human Settlements and the Social Determinants of Health in an Urban Setting”, 9 July 2008.
 - 24 World Migration 2008: Managing Labour Mobility in the Evolving Global Economy. Geneva: IOM
 - 25 Hammoury N. and others (2009). Domestic violence against women during pregnancy: the case of Palestinian refugees attending an antenatal clinic in Lebanon..J Womens Health (Larchmt), Vol. 18, No 3, pp. 337-345.
 - 26 Wolf, and others (2008). Undocumented migrants lack access to pregnancy care and prevention. BMC public health, 8:93. Available from: <http://biomedcentral.com/1471-2458/8/93>
 - 27 Zimmerman, C. and others (2003). The Health Risks and Consequences of Trafficking in Women and Adolescents: Findings from a European study. London: London School of Hygiene and Tropical Medicine
 - 28 UNDP (2008). HIV vulnerabilities of migrant women: from Asia to the Arab States. Shifting from silence, stigma and shame to safe mobility with dignity, equity and justice. Colombo: United Nations Development Programme - UNDP. Available from: http://www2.undprcc.lk/resource_centre/pub_pdfs/P1105.pdf

Chapter 10

CONTRIBUTION OF NON-GOVERNMENTAL ORGANIZATIONS

Overview

This year, non-governmental organizations (NGOs) in consultative status with the Economic and Social Council (ECOSOC) made a significant contribution through multiple channels. One of them was the great variety of events organized to discuss and provide new perspectives on the 2009 theme of the Council “Implementing the internationally agreed goals and commitments in regard to global public health”. This work was coordinated by the NGO Branch, Office for ECOSOC Support and Coordination in the Department of Economic and Social Affairs (DESA).

In the area of global public health, the role that civil society has in mobilizing resources, developing new practices and working in conjunction with multiple stakeholders to support the achievement of the internationally agreed goals, including the Millennium Development Goals (MDGs) is well known. This important contribution was manifested through a number of events put together by the DESA/NGO Branch and other partners, while allowing the exchange of experiences, and engaging in productive debate and canalizing the contribution of NGOs to the 2009 high-level segment (HLS) and the third Annual Ministerial Review (AMR).

During the AMR, and following the successful results obtained in 2008, a total of eight NGOs delivered oral presentations during the four days of the meeting, in which multiple stakeholders got together to discuss the progress made and the steps needed to improve global public health in order to achieve the internationally agreed development goals, including the MDGs. In addition, 33 NGOs submitted written statements, which were distributed among all participants and made available on-line as part of the official ECOSOC documentation.

As a very successful informal mechanism, the 2009 AMR Innovation Fair provided a space for exchanging information and best practices in the area of global public health. Simultaneously, over 20 success stories relating to this year’s theme of the AMR were uploaded to the Civil Society Best Practices Network by NGOs in consultative status with ECOSOC and virtually showcased during the ECOSOC Innovation Fair, at a booth organized by the UN-DESA NGO Branch and the Special Unit for South-South Cooperation (SU/SSC) of the United Nations Development Programme (UNDP). Within this context, the side event “Building partnerships and financing cooperation across developing countries: Trends and opportunities for NGOs” was organized jointly by these two units.

In addition, the Civil Society Development Forum in New York, 2-4 July 2009, gathered representatives of member organizations of the Conference of Non-Governmental Organizations in Consultative Relationship with the United Nations (CONGO) to discuss

and draft recommendations for ECOSOC Member Governments in the course of their deliberations.

Building Partnerships and Financing Cooperation across Developing Countries: Trends and Opportunities for NGOs

Geneva, 7 July 2009
United Nations, Palais des Nations

The side event "Building partnerships and financing cooperation across developing countries: Trends and opportunities for NGOs", organized by the UN-DESA NGO Branch and the UNDP Special Unit for South-South Cooperation, held at the Palais des Nations on 7 July, focused on the Civil Society Best Practices Network web portal and the Human Development Stock Exchange, and how to forge partnerships between institutions that offer solutions in advancing human development, institutions looking for quality practices to address similar needs and how to facilitate social investment in proven solutions in order to advance human development, as well as how to seek funding so as to replicate their success.

The event was chaired by H.E. Mr. Francis Lorenzo, Ambassador of the Dominican Republic to the United Nations, and included opening remarks by Mr. Andrei Abramov, Chief, NGO Branch, OESC/DESA, and Mr. Yiping Zhou, Director, Special Unit for South-South Cooperation in UNDP.

The event was part of a participatory formulation process for the development of the UN-DESA Civil Society Best Practices Network and the pilot programme Human Development Investment Exchange (HDSX).

Civil society best practices Network web portal:

- allows NGOs in consultative status with ECOSOC to submit and share success stories and best practices;
- empowers awareness with regard to the work being carried out by NGOs around the world; and
- further increases the relationships between civil society and the United Nations.

Human development stock exchange - a virtual marketplace:

- to forge partnerships between institutions offering solutions to advance human development and institutions looking for quality practices to address similar needs, and
- to facilitate social investment in proven solutions to advance human development and seeking funding so as to replicate their success.

The Global South has a burgeoning civil society and a plethora of knowledge, know-how and resources to advance human development.

Encouraging the sharing of experiences and cooperation among Southern countries can advance human development in manners that traditional aid or local initiatives are unable to do alone. The panel presented current experiences and discussed challenges and trends transforming social capital markets and leading to the need for specialized mechanisms for brokering transactions, where a large number of players interact with emphasis on opportunities for NGOs.

Civil Society Development Forum Geneva Component¹

Geneva, 2 – 4 July 2009
United Nations, Palais des Nations

Threats to the Health and Sustainable Development of Nations
(Civil Society Proposals on Global Public Health in the Context of the
Global Economic Crisis)

1. We, representatives of member organizations of the Conference of Non-Governmental Organizations in Consultative Relationship with the United Nations (CoNGO), and other civil society groups, convened in Geneva, Switzerland, from 2 to 4 July 2009, for the Civil Society Development Forum (CSDF). We discussed issues germane to the agenda of the high-level segment of ECOSOC's substantive session—on global public health, to be held in Geneva, from 6 to 9 July 2009. Our conclusions and recommendations were prepared for careful consideration by ECOSOC Member Governments in the course of their deliberations and decision-making at this session.
2. We gathered at a time when the worldwide food, energy and environmental crises were reinforced by the devastating effects of the financial and economic crises. The combination of these crises is threatening the socio-economic roots and stability of the Global North and inflicts even greater burdens, with debilitating effects, on the Global South, cancelling momentary socio-economic gains achieved over the last three to five years.
3. Now, more than ever, United Nations Member States must reaffirm their commitment to fulfill the promises they made with regard to official development assistance, and for Member States and the international financial institutions to take into account the conclusions and recommendations of the United Nations Conference on the World Financial and Economic Crisis and Its Impact on Development held in June 2009, in New York. These recommendations reminded all States and international financial institutions to ensure adherence to the social and economic rights of the most vulnerable, especially their right to health.
4. Attaining the Millennium Development Goals (MDGs) by 2015 is in greater jeopardy ever since their promulgation by the leaders of the world nine years ago. The combined threats of the failure to achieve the MDGs, which are cross-sectoral goals, the current paralysis in foreign assistance policies, and the misallocation of national budgets to favour non-productive and military activities are likely to harm the delicate interrelationship between the pursuit of human rights and poverty eradication, global public health and development, and gender equality and the

empowerment of women. These are threats to the good intentions to address the social determinants of health.

5. In six workshops, CSDF 2009 delved deeply into its overarching theme of “Threats to the health and sustainable development of nations”. Three keynote themes were also explored: (i) the social determinants of health; (ii) impacts of the global economic crisis on health; and (iii) threats to the achievement of the MDGs, especially those relating to global public health. Following are the major points arising out of those workshops, including the elements of a special report from the youth participants who attended these workshops:

Responding to Health Inequities at Local and International Levels

6. Governments are increasingly aware of the value of competent civil society input for their policy deliberations and decision-making. In the public health field, the input of numerous international and national advocacies, scientific and community-based civil society organizations can enhance government policies. We call on governments and parliaments to take full advantage of these competencies. Meeting the full range of health needs requires partnership: civil society is ready and able to contribute constructively.
7. The conversion of international agreements into national legislation and practical implementation mechanisms frequently reveals inadequacies. Civil society calls on governments to fulfill their obligations as the credibility of government institutions in this adoption process is at stake. A review of the internationally agreed development goals and commitments, including the MDGs relating to public health, is of key importance.
8. It is critical for governments to adopt a human rights-based approach to health, which would contribute towards attaining the MDGs. This approach redefines health beyond being a mere state and recognizes it as a potential for people to deal with challenges to their bodies and the social determinants of their health. It is a potential to become fully human and humane. Health care must be affordable, acceptable, accessible, and adaptable. It must also be socially responsive, policy-based, contextually appropriate, and gender sensitive. Primary health care should, in itself, be comprehensive by focusing on all aspects of prevention, cure and care, and to healing and wholeness.

Dealing with the shortage of health care workers

9. Policies need to be designed to reduce the brain drain of health care workers and to achieve their equitable distribution compatible with community needs. Education and training must encompass all levels of health care personnel, including local and grassroots community workers and managers, social workers, psychologists, psychiatrists, nurses and medical doctors. Decent wages and working conditions are key to ensuring retention and a rationalized migration policy in both sending and receiving countries.
10. We stress the importance of a holistic approach to health and capacity building. The inclusion of indigenous medical specialists and traditional healers is essential for

comprehensive health care delivery. Their marginalization in society and the discrimination of their expertise are directly linked to poor health services and endanger the availability and viability of health care at the local level.

11. We emphasize the importance, as does WHO, of defining health as encompassing mental, physical and social well-being. Depression is projected to be the greatest risk factor in terms of global disease burden, surpassing all physical illnesses combined by 2030. Women are already at greater risk for depression worldwide. Yet, mental health is missing from the global public health agenda.

Addressing the increase in non-communicable and chronic diseases

12. The increasing trend of non-communicable and chronic diseases is leading to a shift away from infectious communicable diseases in the overall global disease burden. The former diseases tend to be under-diagnosed, especially among the poorest, the most vulnerable and the ageing thus, endangering timely treatment among large population groups, often in an environment of inadequate health system infrastructure. The growing incidence of these diseases results in a reduction in the quality and length of life and in excessive actual costs and social opportunity costs. It is incumbent on governments to issue health-related regulations to meet and promote public health interests outside of industry's profit maximization strategies and to develop constructive public-private health policy partnerships.
13. The advance of non-communicable and chronic diseases must be stemmed by helping remove unhealthy life conditions and lifestyles. Conditions such as health illiteracy, toxic environments, impediments to treatment and care need to be eradicated. Harmful lifestyles, such as inadequate nutrition, drug abuse, alcoholism, tobacco smoking, and the consumption of other toxic products and dependencies need to be abandoned. Multi-sectoral, gender-based, comprehensive strategies pursued by civil society, including also health professionals, scientists, faith-based organizations, the private sector and policy-makers, must be set up for effective global action.
14. Concrete follow-up action should comprise (i) the inclusion in the MDGs and United Nations agency programmes of quantifiable action against the spreading of communicable, non-communicable and chronic diseases; (ii) the creation of a Global Fund to address such diseases that do not have such funding mechanisms; (iii) the adjustment of international health regulations to include a strengthened focus on such diseases and the management of risk-related factors; (iv) the revision of international trade agreements and legislation in favour of healthy food and decent labour - related productivity standards and markets; and (v) political action highlighting the right to health, including access to quality medicine and health care for all, the facilitating of the local manufacturing of safe medicine, covering also the development and production of generics and traditional medicine.

Financing global access to health including health technologies

15. Health financing by governments should go beyond financing health care systems but include investing in the preconditions of health, including freedom, education and economic welfare. In so doing, financing health should not be seen as an

economic burden but an investment in people contributing to sustainable development and gross national product. Health systems function properly with several key elements, such as adequate numbers of skilled health workers, basic infrastructure and equipment, essential medicines and supplies and health financing systems. They underscore the importance of establishing effective health information systems.

16. Ancestral indigenous people's medicine must be recognized and respected, and adopt health policies that take into account the particular realities in each country. The holistic approach of indigenous medicine complements western medicine and needs to be included when shaping national health policy and practice. A change of attitude, including an intercultural approach, should take place to overcome the hegemonic approach of modern medicine as the only existing answer to health care. Efforts should be made to shift towards a harmonious coexistence of both modern and ancestral medicine for the benefit of all peoples.
17. Communities, as well as states, should create their own programmes to make their health system more efficient. Public housing, spaces, and conveyances, including traffic facilities, should be made accessible so as to reduce medical and care-giving costs. Promotion of innovative user-oriented information and communications technology (ICT) could support independent living, especially for elderly and disabled persons. Skills and infrastructure for low-income countries need to be developed to enable them to use ICT, such as e-Health and m-Health for medical education and information systems. Use of ICT will reduce costs and lead to a better and more efficient health care system. As with all technologies, like wireless technologies, their use must be thoroughly evaluated for implications on health.

Ensuring the right to health for women throughout the life-cycle

18. Women's health, including reproductive health, must be promoted throughout their lifecycle by providing gender - sensitive medical care. Healthy mothers and healthy babies make for healthy societies. Continuing and expanding financial and political support for MDG 5 is critical. We must break out of the scandalous lack of progress on this goal. Investing in maternal and child health is a precondition for the health of families, communities and nations and not only the health of half of humanity.
19. Most national budget allocations are used to cover curative services and the recurrent costs of health facilities and services; very few resources are deployed for prevention, promotion and rehabilitation. The availability and accessibility of essential health services are often inadequate. This has resulted in considerable inequalities in health-care provision and access, especially among women and other vulnerable groups.
20. Donor and recipient countries, as well as NGOs, must be supported in introducing good governance, efficient planning, accountability and responsible approaches of communities at regional and local levels. Scientific research into gender medicine needs to be funded to provide data for optimal health programmes, taking into account differences between men and women, age groups and ethnicity.

Promoting prevention and treatment of HIV/AIDS

21. Governments and intergovernmental agencies must broaden the concept of HIV/AIDS prevention and address the social determinants of health regarding vulnerable populations, including women and people who live in abject poverty and hunger. Resources for HIV/AIDS programmes are threatened by the financial crisis which should not be used as an excuse to stop funding them. Countries need to keep their commitment and allocate resources to address HIV/AIDS. The Global Fund should be made more accessible for HIV/AIDS resources and should work towards ensuring that resources get to the needy. HIV/AIDS programmes and policies should make scaling up possible at the national level.
22. Governments need to commit themselves to keep their promise of 0.7 per cent of their GDP, which would help towards attaining the MDGs. Civil society needs to hold up that issue in ECOSOC's debates. Coherence within United Nations agencies must be encouraged to avoid duplication of services.
23. National health systems should be strengthened and measures taken expeditiously to confront the brain drain phenomenon. Governments should be urged to exercise pressure on pharmaceutical companies and laboratories to produce diagnostic tools, child-friendly medicines, and to provide universal access to antiretroviral drugs. The disbursement of funds for HIV/AIDS programmes at the global level should be closely monitored.

Youth perspectives

24. Empowering youth is an investment for today and the future for their meaningful participation in decision-making for themselves and for society. Promoting youth participation in decision-making is a key element in ensuring the provision of youth-friendly health services, including opportunities for employment and decent wage, and thus a healthy and productive youth population. Increased funding and research must be allocated to attend to young people's health. Greater attention must be given to the high disease burden among youth, including the high prevalence of depression and suicide rates. Health strategies must guarantee accessibility to health services for the youth.
25. Young people need a voice in global governance systems. It is crucial that they can feel a sense of purpose and respect. When encouraged to speak with their opinion being valued, recognizing that "youth speak truth," they are empowered to talk about their experiences. For young people, meaningful participation includes being immersed and knowledgeable about the issues they mostly only hear about. New approaches of communication and dialogue must be explored to relate the daily experience of young people. These dialogues can help initiate change in communities.
26. Many youth are faced with inadequate health care services and feel that the health care system needs to be taken beyond a monetary world. For youth, a new service-based health system should be seen as a social duty and a new global ethic. The idea of "design for all" services should encompass the development of a truly generally

accessible global health network. Accessibility denotes prior access to the system, but what about those who have no access.

Cross-cutting themes and other concerns

27. Civil society advocacy for the MDGs must redound to the betterment of life and living conditions of people around the world, especially the extremely poor and the hungry, who are also the most deprived, oppressed and marginalized. In the economic downturn, we must not renege on ensuring their health and the health of the entire human community. A review of internationally agreed development goals is a reconsideration of humanity's commitments to life-giving and life-enhancing activities. It must give focus to combating activities and tendencies that deal with, and peddle violence and death, especially wars.
28. CSDF 2009 reaffirmed the intersections and interdependence between human rights, peace and security, and sustainable development. These values undergird, enhance and sustain a healthy human life and the planet. Human right to health is equally the human right to a healthy and sustainable ecological system. Food, an essential element of health, must be ensured for all. Without food, health goals are meaningless. Profit entities and structures, especially those affecting the food production and distribution chain, must favour and ensure availability of safe, healthy and affordable food for all. No one should gain and make profit from making people sick.
29. Global public health is a challenge to socio-economic policies. Health is not primarily an economic outlay but the foundation for productivity and the enjoyment of human rights and dignity. Public health cannot be a mere consumer good for it is a fundamental building block of society. The right to and equal access to health care implies a just and equitable health for vulnerable populations. Thus, society needs to ensure that public policies consider the implications of social and economic conditions--determinants that either increase or decrease the risk and vulnerability of specific populations.
30. The use and abuse of alcohol is a global problem that spans both physical and mental health. It is multi-faceted with issues varying across cultures. The benefits connected with the production, sale and use of alcoholic beverages come at an enormous cost to society. Acute and chronic disease and psycho-social problems are integrally linked. Physical toxicity, intoxication, and dependence explain alcohol's ability to cause medical, psychological, and social harm. Like WHO, NGOs must be mobilized to promote alcohol policies which safeguard from the negative consequences of alcohol abuse and addiction, enjoining everyone to own the problem and help monitor alcohol marketing. NGOs must help foster political will to reduce the global burden of disease caused by alcohol.
31. Health information for people and communities involves access to information for health promotion, health education, health literacy and awareness. These require consideration of legal and ethical aspects such as the quality and credibility of information, whether or not it is evidence-based, the source, conflicts of interest, and consent. Access to information across organizational and geographic boundaries

should not limit access to health data and information, but must be managed through agreed protocols for data protection, privacy and authenticity.

32. E-health is an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the internet and related technologies. E-health is more than a technical development, it is a way of and a commitment for networked and global thinking, to improve healthcare locally, regionally, and globally by using information and communications technology. A national e-Health legislative framework should provide the basis for protecting data, users and citizens from misuse.

Notes

- ¹ The Civil Society Development Forum is the fourth in a series organized by the Conference of Non-Governmental Organizations in Consultative Relationship with the United Nations (CONGO) prior to the ECOSOC high-level segments. The 2009 Forum consists of a component in Geneva, with a follow-up component in New York later in the year to examine action taken and further action required.

Annex 1

REPORT OF THE SECRETARY-GENERAL*

Theme of the Annual Ministerial Review: Implementing the Internationally Agreed Goals and Commitments in Regard to Global Public Health

Summary

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

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

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

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

I. Introduction

Promoting and securing health is an ethical imperative and a foundation for prosperity, stability and poverty reduction. Health is at the heart of the Millennium Development Goals and a critical precondition for progress on most of those Goals.

Over the past decade, progress in improving global health has been mixed. The gains in the prevention and treatment of HIV/AIDS, tuberculosis and malaria are encouraging. However, other areas like improving maternal and newborn health still need much more attention. Similarly, diseases of the poor such as neglected tropical diseases, and a growing number of health problems associated with non-communicable diseases continue

* See the document E/2009/81

to be widespread, notwithstanding the fact that for the most part they are easy to prevent and treat.

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

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

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

Financial resources for health have increased dramatically in recent years, in large part channelled through the multilateral efforts of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the work of the Global Alliance for Vaccines and Immunization, the engagement of the Gates Foundation, bilateral initiatives such as the United States President's Emergency Plan for AIDS Relief, and innovative financing mechanisms such as the international drug purchase facility, UNITAID. The dramatic expansion of funding, the surge of many players in the global health arena, as well as the high priority that the Secretary-General has given to the issue provide an important opportunity for progress.

At the same time, the growing number of new initiatives poses a challenge for coherence and coordination. Those initiatives have also left the global health sector fragmented and without long-term predictable financing to support the underlying health system. For that reason, greater coherence across initiatives and across sectors that contribute to improving health and the support and coordinated involvement of all areas of society are essential.

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

II. Global health today

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

As a result of improvements in prevention programmes, the number of people newly infected with HIV declined from 3 million in 2001 to 2.7 million in 2007. Also, with the expansion of antiretroviral treatment services, the number of people who die from AIDS has started to decline, from 2.2 million in 2005 to 2 million in 2007. Following almost two decades of rapid epidemic expansion, those reversals constitute significant progress. HIV prevention has been successful in reducing high-risk sexual behaviours in the general population of many countries. Programmes to prevent mother-to-child transmission have also expanded. However, other indicators are less encouraging and much more needs to be done to achieve the full impact of scaled-up prevention programmes. It is critical to ensure linkages, and integrate service delivery models, between maternal, child and sexual and reproductive health programmes and HIV services. Sufficient political commitment, resources and programmes are needed to reach stigmatized populations vulnerable to HIV infection and its impact. These include injecting drug users, men who have sex with men, and sex workers. Coverage of interventions to prevent HIV among drug injectors has remained low. Stigma and discrimination persist. The vast majority of those living with HIV are in sub-Saharan Africa. Globally, women account for 50 per cent of people living with HIV and, in sub-Saharan Africa, the proportion of women is as high as 60 per cent. By the end of 2007, less than a third of the 9.7 million people in need of AIDS treatment in developing countries were receiving the necessary drugs.

There has been tremendous progress in prevention of malaria so far, but much still is left to be done, particularly in treating the disease. The number of insecticide-treated mosquito nets produced worldwide jumped from 30 million in 2004 to 95 million in 2007, which has led to a rapid rise in the number of mosquito nets distributed. As a result, out of 20 sub-Saharan African countries for which there are trend data, 16 have more than tripled their coverage since around 2000. Despite this progress, use of insecticide-treated mosquito nets falls short of global targets and efforts in this regard must increase.

Success in eradicating tuberculosis rests on early detection of new cases and effective treatment. Between 2005 and 2006 progress in detection slowed, and the detection rate increased only marginally. Africa, China and India collectively account for more than two thirds of undetected tuberculosis cases. The detection rate in Africa — 46 per cent in 2006 — is furthest from the target. Despite its success, Directly Observed Treatment Shortcourse has not yet had the impact on worldwide transmission and incidence needed to achieve the targets of halving the world's 1990 prevalence and death rates by 2015. To accomplish the targets, regions that lag behind will have to improve both the extent and

timeliness of the diagnosis of active tuberculosis and increase the rate of successful treatment, including diagnosis and treatment of HIV-associated tuberculosis and multi-drug-resistant tuberculosis. Diagnosis and successful treatment of multi-drug resistance are of particular concern and are lagging behind globally, especially in the three countries that account for 57 per cent of global cases.

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

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

The least progress has been made in improving maternal and newborn health, with Millennium Development Goal 5 lagging behind most of the other Goals. Maternal mortality remains unacceptably high across much of the developing world. In 2005, more than half a million women died as a result of pregnancy-related complications. Of those deaths 92 per cent occurred in the developing regions, with sub-Saharan Africa and Southern Asia accounting for 86 per cent of them.

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

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

Maternal and newborn health are areas that lack sufficient resources, the necessary political will and high-level leadership. Greater investment in well-managed health systems, particularly primary care, will be essential if progress is to be made. Better health outcomes for mothers and newborns will be the ultimate measure of the success of investment in health systems. If a health system is available and accessible 24 hours and 7 days a week to handle normal deliveries and emergencies, it means it is equipped to provide a wide range of other services as well. Advances on health systems and maternal health are mutually reinforcing.

Maternal and newborn health are also linked with education of both women and men and women's access to economic resources. In almost all regions, the net enrolment ratio in 2006 exceeded 90 per cent; many countries were close to achieving universal primary enrolment with the exception of sub-Saharan Africa, where about 38 million children of primary school age are still out of school. Some strides have also been made in promoting gender equality and empowering women, but much more needs to be done. Equal access to primary school remains elusive for girls, despite some gains. Girls' primary enrolment increased more than boys' in all developing regions between 2000 and 2006, yet girls account for 55 per cent of the out-of-school population. Overall, women occupy almost 40 per cent of all paid jobs outside agriculture, compared to 35 per cent in 1990. But, almost two thirds of women in the developing world work in vulnerable jobs and as unpaid family workers. Women are also disproportionately represented in part-time, seasonal and short-term informal jobs and therefore are deprived of job security and benefits.

III. Sustaining progress in times of crises¹

The past two years have seen a dramatic sequence of global crises which have and will continue to affect efforts to improve global health: food insecurity, climate change, conflict, and most recently the economic crisis. The interplay between these dynamics is testimony to the increasing complexity and interconnectedness of the current global threats and points to the need for solutions that cross sectoral and national boundaries and engage a wide-range of stakeholders. The H1N1 flu outbreak is a direct reminder that diseases know no borders and require a collective, global response that draws on preparedness and timely information.

A. Impacts of the food crisis on health

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

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

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

The High-Level Task Force on the Global Food Security Crisis, established by the Secretary-General in April 2008 and composed of the heads of the United Nations specialized agencies, funds and programmes, Bretton Woods institutions and relevant parts of the United Nations Secretariat, promotes a unified response to the challenge of achieving global food security. The Comprehensive Framework for Action outlines a twin-track approach — investing in food assistance and social safety nets for those most in need, and at the same time scaling up investment in agriculture in developing countries, increasing opportunities for people and enabling them to feed themselves, ensure adequate nutrition and sustain an increase in income. In order to meet Millennium Development Goal 1, as well as all health Millennium Development Goals and the Millennium Development Goals as a whole, it is necessary to give continued priority to the food and nutrition security of vulnerable groups.

B. Climate change and health

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

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

temperatures will increase levels of important air pollutants, such as ground-level ozone, particularly in areas that are already polluted.

In order to minimize the increase of health risks, help communities cope, particularly those most vulnerable, and make progress towards achieving the Millennium Development Goals, it is an imperative that the intergovernmental negotiations on climate change under the United Nations Framework Convention on Climate Change are successful with regard to mitigation of and adaptation to climate change. This is the responsibility of Governments, which must show increasing determination to live up to that responsibility. They must dedicate more time and effort to these negotiations and work together towards “sealing the deal” in Copenhagen at the end of 2009.

C. Countries emerging from conflict and natural disaster and health

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

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

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

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

D. Current financial and economic crisis and health

The scale and reach of the current financial crisis has left the world economy facing a rapidly deteriorating outlook. The financial crisis has led to a credit crunch and lowered asset values, constraining household spending and curtailing production and trade. Global output and trade plummeted in the final months of 2008. The world economy is forecast to contract by about 2.0 per cent in 2009. Under a more pessimistic scenario, however, world gross product is expected to decline by 3.5 per cent this year.³ Growth in emerging and developing economies is expected to slow from 6¼ per cent in 2008 to 3¼ per cent in 2009, owing to falling export demand and financing, lower commodity prices, and much tighter external financing constraints.⁴ The World Trade Organization (WTO) estimates that global exports volume will decline by approximately 9 per cent — the largest decline since the Second World War. Developed economy exports are expected to fall by some 10 per cent on average and developing country exports are expected to shrink by 2-3 per cent.

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

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

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

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

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

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

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

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

IV. Development cooperation for health

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

Aid

Aid, trade and debt relief are vital for developing countries that are already burdened with straitened financial circumstances and competing needs. Total official development assistance (ODA) flows from Development Assistance Committee of the Organization for Economic Cooperation and Development countries increased to \$119.8 billion in 2008 from \$103.7 billion in 2007. Until 2006, an increasing share of all ODA was being devoted to health. Total bilateral commitments to health in the period 1980-1984 averaged \$2.8 billion (constant 2006 dollars), or 5.3 per cent of all ODA. This increased to an average of \$6.4 billion in the five years to 2006, equivalent to 7.8 per cent of all ODA, after remaining unchanged in all of the 1990s.⁶

In recent years, total aid for health from official and private sources has more than doubled, to about \$16.7 billion in 2006, up from \$6.8 billion in 2000. There are, however, disparities between the amount of aid for health received by countries — Zambia receives \$20 per person for health, Chad just \$1.59. The challenge now is to scale up aid to levels that will make it possible to achieve the Millennium Development Goals. For

this to happen, aid needs to be used more effectively and challenges highlighted in the Paris Declaration need to be addressed.

Aid targeted towards the health sector has made a significant contribution to health gains achieved so far, particularly in the area of HIV/AIDS, malaria and tuberculosis. But much more needs to be done, both by donor countries and recipients. Analysis of trends over the past 10 years shows aid for health is fragmented into large numbers of small projects; more than two thirds of all commitments were for less than \$500,000. Relatively little is provided directly into country budgets. This makes it harder for developing countries to influence what aid is provided for or how it is provided. Aid for health still needs to be much more aligned to country priorities and, where possible, channelled through their national health plans. At the global level, there needs to be a better match between the needs of individual countries and the support they receive from donors to address them.

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

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

Trade

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

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

Debt relief

In 2005 ODA was boosted by the exceptional debt-relief initiatives for heavily indebted poor countries (HIPC). Donors will need to increase programmable aid (which excludes debt relief) in order to meet the 2010 aid target to increase total aid by \$50 billion overall and aid to sub-Saharan Africa by \$25 billion a year (in 2004 dollars). The HIPC Initiative and Multilateral Debt Relief Initiative (MDRI) have drastically decreased the debt burdens of many low-income countries. For example, debt relief under the HIPC Initiative reduced burdens of external debt service for 34 post-decision-point highly indebted poor countries. Assistance under the MDRI Initiative further reduced the external debt of 23 post-completion-point countries.⁷ However, maintaining long-term debt sustainability will be difficult.

V. Challenge of inequities in health and access to health services

A. Inequities in health outcomes

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

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

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

Civil society should contribute by assisting Governments in taking action in this area. Evidence shows that engagement of communities in decisions that affect their health, including health services, increases the likelihood that policies and actions will be appropriate, acceptable and effective. In addition, in some countries non-governmental organizations provide a substantial share of health services. Civil society organizations

can have an impact through advocacy, monitoring and giving a voice to the most disadvantaged. Women's organizations and AIDS activists have been among the most successful of such groups. Labour organizations also have a role to play.

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

B. Towards universal coverage

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

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

VI. Strengthening systems for health

Without urgent improvements and long-term commitments to make health systems functioning, accessible and affordable, the health Millennium Development Goals will be difficult to achieve. The Secretary-General has identified the need to strengthen health systems as a critical area that needs concerted action across and beyond the United Nations system, and has made this a priority for his tenure. Efforts to address the human resources crisis and to protect the poor from catastrophic out-of-pocket health expenditures are particularly important.

Health systems provide the base for the dramatic scale-up of interventions that is needed to meet the health Millennium Development Goals. Contributions from disease-specific programmes are essential. There is a great deal to learn from the work of global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization and the United States President's Emergency Plan for AIDS Relief, among others. Their focus on a specific disease is complementary and includes efforts to ensure well-managed, adequately staffed and well-equipped health systems with the capacity for delivering prevention and care interventions. The challenge

is to scale up and strengthen services for health in a coherent manner beyond these initiatives.

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

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

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

VII. Health in all policies

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

policies. Where such intersectoral collaboration has been successful, the health benefits have been considerable.

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

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

Global health issues are receiving greater attention than ever before, with more players contributing to a multitude of initiatives that seek to address both specific diseases as well as health systems issues. The increase in initiatives is welcome but brings challenges for coordination and coherence. There is a growing need to work together across traditional boundaries and in new ways.

The Secretary-General has made explicit the need for Member States and the United Nations to involve and work with civil society, the private sector, foundations and academia. To that end, he has brought together leaders of United Nations entities, representatives from key civil society organizations, Chief Executive Officers of private sector institutions, heads of major foundations and representatives from the academic world to join forces for priority global health issues and push for concerted action.

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

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

There are lessons to be learned from the partnerships forged to deal with AIDS and malaria. First, it is possible for very different groups to work together around a common cause, and one that seems complex and daunting. Second, with such partnerships, scaling up is possible. Third, it is important to involve those directly affected by the issue in developing policies and planning action. Fourth, partnerships are important at all levels — community, national and international — to address the different challenges at each

level. Global health partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID and the Global Alliance for Vaccines and Immunization have made major contributions to increasing the resources available and bringing new dynamics into the public health sector. The potential power of partnerships to mobilize different players to work together in new ways needs to be explored further.

Regional meetings

Five country-led regional meetings^a were held in support of preparations towards the annual ministerial review in the Economic and Social Council in July. These meetings provided an opportunity for multi-stakeholder engagement, including — Governments, civil society, United Nations system institutions and the private sector. They also provided an opportunity to prepare the launch of new partnership initiatives at the annual ministerial review July 2009 session, in Geneva.

- A South Asia regional preparatory meeting on the theme “Financing strategies for health care” was held in Colombo from 16 to 18 March 2009, by the Government of Sri Lanka. Issues discussed at this meeting were: (a) domestic financing for healthcare; (b) external financing for health care; (c) challenges for health systems in countries in or following crisis; (d) progress and challenges in achieving the Millennium Development Goals
- An Asia Pacific regional ministerial meeting on the theme “Promoting Health Literacy” was held on 29 and 30 April 2009 in Beijing. The focus of the meeting was the following: (a) the challenges of health literacy in Asia and the Pacific; (b) promoting multisectoral actions; (c) promoting health literacy through media and empowerment; (d) building capacity to increase health literacy
- A Western Asia regional ministerial meeting was held in Doha on 10 and 11 May on the theme “Addressing non-communicable diseases and injuries: major challenges to sustainable development in the twenty-first century”. The issues discussed at the meeting were: (a) the global and regional magnitude of non-communicable diseases and injuries and their impact on socio-economic development and poverty reduction strategies; (b) integrating the care of non-communicable diseases into primary care; (c) multi-stakeholder approaches to meet the challenges of non-communicable diseases and injuries; (d) new initiatives to address non-communicable diseases and injuries
- A regional ministerial meeting in Latin America and the Caribbean is scheduled to be held on 5-6 June 2009 in Kingston, Jamaica, on the progress in the reduction of the HIV/AIDS pandemic and its interconnection with regional public health and development goals. At that meeting the following key topics will be discussed: (a) the status of the HIV/AIDS epidemic in Latin America and the Caribbean; (b) lessons learned and best practices in the response to HIV/AIDS; (c) response of Governments in the region to current global and regional economic trends and the likely implications for the fight against HIV/AIDS

- An African regional ministerial meeting is to be held in Accra, in June 2009. The meeting focuses on e-health. The following topics will be examined at the meeting: (a) strengthening policies for provision of information and communications technologies for health; (b) supporting equity of access and protection for all; (c) promoting the growth of e-health capacity, tools and services.

^a Outcomes of these meetings will be presented as a Conference Room Paper after their conclusion.

IX. Priority actions and recommendations

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

(1) Developing a comprehensive and integrated approach to achieving the Millennium Development Goals which:

- Strengthens efforts to improve women's health, and in particular maternal and newborn health
- Makes prevention, treatment and control of neglected tropical diseases and non-communicable diseases an integral part of the achievements of the health-related Millennium Development Goals
- Protects and sustains gains achieved in combating AIDS, tuberculosis, and malaria, including dealing with new threats such as multi-drug-resistant extensively drug-resistant tuberculosis
- Invests in infrastructure and delivery systems to expand the impact of and build synergies with vertical health programmes
- Invests in public health systems required for surveillance and responses to potential outbreaks of disease and other public health emergencies under the International Health Regulations
- Strengthens local authorities in environmental sanitation and waste management in collaboration with health authorities.

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

- Progressively expanding access to a comprehensive package of health services (including adequate health workforce, financing, and information)
- Providing financial protection from catastrophic health costs, moving away from user fees in developing countries and promoting prepayment and pooling schemes

- Working towards finding innovative ways for recruiting, training and retaining health workers and professionals and creating a critical mass of community health workers
- Supporting an international mechanism to track movements of health-care workers, nurses and doctors and conduct studies on migration trends to be able to assist Governments in developing targeted interventions to promote brain-drain “reversals”
- Building and strengthening health information systems for identifying and understanding gaps, successes and trends and for accountability
- Investing in information and communication technologies and health education to (a) establish direct communication networks among experts, therapists, caretakers and patients; (b) support system-wide implementation strategies for treatment and preventive practices; and (c) make populations aware of health risks and health services provided
- Supporting affordable public transportation services and access to energy to ensure accessibility and availability of health care services.

(3) Promoting health as an outcome of all policies through:

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

(4) Promoting greater coherence through:

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

(5) Building and strengthening partnerships through:

- Finding ways to bring in new partners and build synergies
- Building productive and people-centred partnerships with the private sector in the maintenance of health-care facilities and utilization of virtual and mobile technology to provide health advice and services and raise health awareness
- Exploring operational partnerships with faith-based organizations to reach communities in disseminating information and coaching on health

- Providing a platform to connect policymakers, researchers, health promoters, educators, and parents to exchange up-to-date science and best practices for prevention, treatment and control.

(6) Sustaining and enhancing financing for health and development by:

- Allocating adequate resources despite the economic downturn to reach the poorest and most vulnerable
- Ensuring national and community ownership by harmonizing allocations of national budgets and external aid. Monitoring and evaluation should feed into nationally led planning processes
- Focusing on the implementation and monitoring of international commitments
- Making external funding more predictable and well-aligned with country national priorities and channelling resources to recipient countries in ways that strengthen national financing systems
- Promoting collective actions by all stakeholders in order to ensure higher levels of funding for meeting the challenges of global public health, including alliances for innovative funding.

X. Conclusion

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

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

Notes

- 1 This section is to be read in conjunction with the annual report of the Secretary-General on the work of the Organization (A/64/1), the report of the Secretary-General on the Theme of the 2009 high-level segment of the Economic and Social Council: Current global and national trends and their impact on social development, including public health, the Millennium Development Goals Report 2008 and 2009.
- 2 FAO, 2008.
- 3 United Nations/Department of Economic and Social Affairs, *World Economic Situation and Prospects: update as of mid-2009* (forthcoming), updating United Nations publication, Sales No. E.09.II.C.2.
- 4 International Monetary Fund, *World Economic Outlook, Update*, 28 January 2009.
- 5 World Bank, "Crisis Hitting Poor Hard in Developing World", Press Release No. 2009/220/EXC, Washington, D.C., 12 February 2009.
- 6 Effective Aid, Better Health: report prepared for the Accra High-level Forum on Aid Effectiveness, 2-4 September 2008, WHO, World Bank, OECD.
- 7 Global Monitoring Report, annex (World Bank, 2009).
- 8 Resolution WHA57.19.

Annex 2

MINISTERIAL DECLARATION***Implementing the internationally agreed goals and commitments in regard to global public health**

“We, the Ministers and Heads of Delegations, participating in the high-level segment of the substantive session of the Economic and Social Council, held in Geneva from 6 to 9 July 2009,

“Having considered the themes of the high-level segment, ‘Implementing the internationally agreed goals and commitments in regard to global public health’ and ‘Current global and national trends and their impact on social development, including public health’,

“Recalling the outcomes of the major United Nations conferences and summits in the economic, social and related fields, especially those related to global health,

“Recognizing the leading role of the World Health Organization as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate,

“Recognizing also that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health,

“Recalling that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,

“Having considered the reports of the Secretary-General¹ and the deliberations held during the high-level segment,

“Taking note with appreciation of the voluntary initiatives of the Governments of China, Ghana, Jamaica, Qatar and Sri Lanka to host regional preparatory ministerial meetings in Beijing, Accra, Montego Bay, Doha and Colombo, respectively, for the annual ministerial review,²

“Welcoming the voluntary national presentations made by China, Jamaica, Japan, Mali, the Plurinational State of Bolivia, Sri Lanka and the Sudan,³

“Expressing concern at the adverse impact of the global financial and economic crisis on the realization of the internationally agreed development goals, including the Millennium Development Goals, particularly the health-related Millennium Development Goals, and on the ability of developing countries to gain access to the financing necessary for their development objectives, in particular those related to public health,

* See the document A/64/3

“Recognizing that the Millennium Development Goals are interlinked and expressing our concern that progress on achieving some of them is lagging, and reiterating our commitment to continue reinvigorating and strengthening the global partnership for development, as a vital element for achieving these goals, in particular the health-related goals,

“Have adopted the following declaration:

“1. We reaffirm our commitment to the achievement of the internationally agreed development goals, including Millennium Development Goals, particularly those related to health, in a timely manner and we reiterate our resolve to expedite realization of the United Nations development agenda.

“2. We recognize that health and poverty are interlinked and that achieving the health-related goals is central to sustainable development.

“3. We reaffirm that good public health is better achieved through a combination of good public-health policies including multisectoral policies that stress better nutrition, safe drinking water, hygiene, sanitation and sustainable urbanization, and effectively combat major risk factors.

“4. We reiterate that each country has primary responsibility for its own economic and social development and that national policies, domestic resources and development strategies cannot be overemphasized. We are determined to develop and strengthen comprehensive, multisectoral, integrated people-centred and results-oriented approaches to achieving the internationally agreed development goals, including the Millennium Development Goals, in order to achieve improved health outcomes and health equity for all among and within countries. We call for political leadership, empowerment of communities and engagement of all stakeholders, including individuals, for attaining these goals with renewed vigour and in the spirit of global solidarity.

“5. We emphasize the need for urgent and collective efforts to improve public health and address the public-health challenges exacerbated by the current and emerging global ‘interrelated’ challenges, in particular:

“(a) The global financial and economic crisis, which is undermining, by slowing or reversing, the development gains of developing countries in the achievement of the internationally agreed development goals, including the Millennium Development Goals;

“(b) The food crisis and continuing food insecurity in many countries, which have affected global health, especially the overall nutrition levels of populations in developing countries, and the social and economic consequences which have direct negative impacts and impair nutritional status;

“(c) Climate change, which poses serious health risks and challenges to all countries, particularly developing countries, especially the least developed countries, landlocked developing countries, small island developing States and countries in Africa, including those that are particularly vulnerable to the adverse effects of climate change.

“6. We emphasize the need for further international cooperation to meet emerging, new and unforeseen threats and epidemics, such as the current influenza A (H1N1) virus

pandemic, and H5N1 and other influenza viruses with pandemic potential, and acknowledge the growing health problem of antimicrobial resistance.

“7. We recognize the need for a fair, transparent, equitable and efficient framework for the sharing of H5N1 and other influenza viruses with human pandemic potential, and for the sharing of benefits, including access to and distribution of affordable diagnostics and treatments, including vaccines, to those in need, especially in developing countries, in a timely manner. We call for strengthening surveillance and response capacity at the national, regional and international levels through the full implementation of the International Health Regulations.⁴

“8. We emphasize the need to strengthen health information systems and the need for the timely transmission of relevant data to the World Health Organization and similar bodies, when novel infection emerges, so as to build essential knowledge regarding the characteristics of the disease; and we call for increased preparedness, as well as capacity-building for risk assessment and technology transfer for risk response in developing countries.

“9. We reaffirm our commitment to strengthening health systems that deliver equitable health outcomes as a basis of a comprehensive approach. This will require appropriate attention to, *inter alia*, health financing, the health workforce, procurement and distribution of medicines and vaccines, infrastructure, information systems, service delivery and political will in leadership and governance.

“10. We recognize the role of social determinants in health outcomes and take note of the conclusions and recommendations formulated by the Commission on Social Determinants of Health,⁵ which aim to improve living conditions, tackle the inequitable distribution of resources, and measure, understand and assess their impact. We call upon the international community to support efforts of States to address the social determinants of health and to strengthen their public policies aimed at promoting full access to health and social protection for, *inter alia*, the most vulnerable sectors of society, including through, as appropriate, action plans to promote risk-pooling and pro-poor social protection schemes, and to include support for the efforts of developing countries in building up and improving basic social protection floors.

“11. We reaffirm our commitment to eliminating hunger and to securing food for all, today and tomorrow, and reiterate that relevant United Nations organizations should be assured the resources needed to expand and enhance their food assistance, and support safety net programmes designed to address hunger and malnutrition, when appropriate, through the use of local or regional purchase.

“12. We emphasize the importance of the promotion and protection of all human rights for all and their important interrelationship with global public health, development, poverty eradication, education, gender equality and empowerment of women.

“13. We call for action to promote gender equality and the empowerment of women and concerted action to ensure the equal access of women and girls to education, basic services, including primary health care, economic opportunities and decision-making at all levels.

“14. We stress the importance of addressing stereotypes and eliminating all harmful practices which constrain the achievement of gender equality and empowerment of women, including through concerted efforts to counteract violence against women and girls, which constitutes a severe threat to physical and mental health. We further stress the importance of strengthening the participation of women in decision-making processes and developing gender-sensitive multisectoral health policies and programmes in order to address their needs.

“15. While noting that some progress has been made in the past decade in advancing global health, we express concern at the lack of overall progress in improving global health, as evidenced by across-the-board inequities in respect of health which persist among and within countries. In particular, we are deeply concerned that maternal health remains one area constrained by some of the largest health inequities in the world and by the slow progress in achieving Millennium Development Goals 4 and 5 on improving child and maternal health. In this context, we call on all States to renew their commitment to preventing and eliminating child and maternal mortality and morbidity, at all levels, which are rising globally at an unacceptably high rate. We call for health system strengthening as a key component of an integrated approach to achieving a rapid and substantial reduction in maternal morbidity and mortality, including through:

“(a) Increased political will, commitment and engagement at the national level supported by international cooperation and assistance to ensure accessibility, availability, acceptability and affordability of health-care services, skilled health workers, facilities, infrastructure and nutritional support for all women and children, with special attention to sub-Saharan Africa;

“(b) Achieving universal access to reproductive health by 2015, through increased political leadership at all levels, allocation of domestic and donor resources and emerging innovative financing and by strengthening basic infrastructure, and specific health interventions, including voluntary family planning, emergency obstetric care and skilled birth attendance;

“(c) Scaling up efforts to achieve integrated management and care of child health, including actions to address the main causes of child mortality, including newborn and infant mortality, these being, inter alia, pneumonia, diarrhoea, malaria and malnutrition, and by developing and/or implementing appropriate national strategies, policies and programmes for child survival, including prevention measures, vaccinations, medicine and improved nutrition, drinking water and sanitation;

“(d) Integrating HIV/AIDS interventions into programmes for primary health care, sexual and reproductive health, and mother and child health, including strengthening efforts to eliminate the mother-to-child transmission of HIV.

“16. We call for the full and effective implementation of the Beijing Platform for Action,⁶ the International Conference on Population and Development (ICPD) Programme of Action⁷ and the outcomes of their review conferences,⁸ including the commitments relating to sexual and reproductive health, and the promotion and protection of all human rights in this context. We emphasize the need for the provision of

universal access to reproductive health, including family planning and sexual health, and the integration of reproductive health in national strategies and programmes.

“17. We recognize that communicable diseases which have been prioritized by the Millennium Development Goals, such as HIV/AIDS, malaria and tuberculosis, as well as other communicable diseases and neglected tropical diseases, pose severe risks for the entire world and serious challenges to the achievement of development goals. In this regard, we emphasize the urgency of:

“(a) Significantly scaling up efforts towards meeting the goal of ensuring universal access to HIV prevention, treatment, care and support by 2010 and the goal of halting and reversing the spread of HIV/AIDS by 2015. We commit ourselves, with the support of international cooperation and multisectoral partnerships, to maximizing synergies between the HIV/AIDS response and strengthening of health systems and social support;

“(b) Enhancing policies established to address the challenges of malaria by strengthening effective prevention and treatment strategies, including ensuring the availability of affordable, good-quality and effective medicines, including artemisinin-based therapy, as well as long-lasting insecticide-treated bednets. Further, in this regard, we welcome the Global Malaria Action Plan developed by the Roll Back Malaria Partnership, which offers, for the first time, a comprehensive plan for combating malaria in the short, medium and long terms, and the Affordable Medicines Facility for malaria;

“(c) Sustaining and strengthening the gains made in combating tuberculosis, and developing innovative strategies for tuberculosis prevention, detection and treatment, including strategies for dealing with new threats such as co-infection with HIV/AIDS, multi drug resistant tuberculosis and extensively drug-resistant tuberculosis;

“(d) Cooperating and further strengthening efforts to control and eliminate neglected tropical diseases, including by accelerating further research and development, developing innovative medicines and adopting prevention strategies;

“(e) Eradicating poliomyelitis worldwide and intensifying immunization activities and country-specific strategies to address the remaining barriers to stopping poliomyelitis transmission, including in developing countries;

“(f) Halving by 2015 the proportion of the population without sustainable access to safe drinking water and basic sanitation as a means of fighting waterborne diseases.

“18. We also recognize that the emergence of non-communicable diseases is imposing a heavy burden on society, one with serious social and economic consequences, and that there is a need to respond to cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, which represent a leading threat to human health and development. In this regard, we:

“(a) Call for urgent action to implement the World Health Organization Global Strategy for the Prevention and Control of Non-Communicable Diseases and its related Action Plan;

“(b) Recognize that diabetes is a chronic, debilitating and costly disease associated with severe complications;

“(c) Stress the need to scale up care for mental health conditions, including prevention, treatment and rehabilitation;

“(d) Reaffirm the importance of the Framework Convention on Tobacco Control⁹ within the sphere of global public health and call upon States parties to the Convention to fully implement it.

“19. We express concern at the continued increase in road traffic fatalities and injuries worldwide, in particular in developing countries, and draw attention to the need to build public awareness and to improve and implement legislation to prevent such accidents. We call for the implementation of existing General Assembly resolutions and welcome the recent initiatives aimed at addressing global road safety issues and strengthening international cooperation in this field.

“20. We note with concern the lack of health workers as well as their imbalanced distribution within countries and throughout the world, in particular the shortage in sub-Saharan Africa, which undermines the health systems of developing countries. In this regard, we emphasize the need for countries to review policies, including recruitment policies and retention policies that exacerbate this problem. We underline the importance of national and international actions, including the development of health workforce plans, which are necessary to increase universal access to health services, including in remote and rural areas, taking into account the challenges facing developing countries in the retention of skilled health personnel. We encourage the finalization of a code of practice on international recruitment of health personnel.

“21. We reaffirm the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, transparency, accountability and community participation and empowerment, as the basis for strengthening health systems, and recall in this regard the Declaration of Alma-Ata.¹⁰ We recognize the importance of providing comprehensive primary health-care services, including health promotion, and universal access to disease prevention, curative care and palliative care and rehabilitation that are integrated and coordinated according to needs, while ensuring effective referral systems.

“22. We stress the importance of multisectoral and inter-ministerial approaches in formulating and implementing national policies that are crucial for promoting and protecting health. We reiterate that Governments will play the central role, in collaboration with civil society organizations, including academia, and the private sector, in implementing national strategies and action plans on social services delivery, and in making progress towards ensuring more equitable health outcomes.

“23. We recognize the close relationship between foreign policy and global health and their interdependence, and in that regard also recognize that global health challenges require concerted and sustained efforts by the international community. We look forward to continuing discussions on this issue.¹¹

“24. We underline the health and rehabilitation needs of victims of terrorism, encompassing both physical and mental health.

“25. We underline our commitment to developing and implementing national strategies that promote public health in programmes or actions that respond to challenges faced by all populations affected by conflict, natural disasters and other humanitarian emergencies, and acknowledge that inequities in access to health care can increase during times of crises, and that special efforts should be made to maintain primary health care functions during these periods, as well as to ensure that the needs of the poorest and most vulnerable are met during the post-crisis, peacebuilding and early recovery stages.

“26. We underline the need of people living in situations of armed conflict and foreign occupation for a functioning public-health system, including access to health care and services.

“27. We call upon all countries to strengthen institutional capacity to pursue longer-term health and development goals and fulfil the need to discharge essential public-health functions as part of the broader post-humanitarian assistance crisis recovery strategy.

“28. We underline the importance of establishing effective financial strategies for health care, including allocating to Government health budgets increased resources and/or using resources more efficiently.

“29. We acknowledge the contribution of aid targeted towards the health sector, while recognizing that much more needs to be done. We call for the fulfilment of all official development assistance-related commitments, including the commitments by many developed countries to achieve the target of 0.7 per cent of gross national income for official development assistance by 2015 and to reach the target of at least 0.5 per cent of gross national income for official development assistance by 2010, as well as the target of 0.15-0.20 per cent of gross national income for official development assistance to least developed countries, and urge those developed countries that have not done so to make concrete efforts in this regard in accordance with their commitments.

“30. We welcome increasing efforts to improve the quality of official development assistance and to increase its development impact. The Development Cooperation Forum of the Economic and Social Council, along with recent initiatives such as the High-level Forums on Aid Effectiveness, which produced the 2005 Paris Declaration on Aid Effectiveness and the 2008 Accra Agenda for Action,¹² make important contributions to the efforts of those countries that have committed to them, including through the adoption of the fundamental principles of national ownership, alignment, harmonization and managing for results. We should also bear in mind that there is no one-size-fits-all formula that will guarantee effective assistance. The specific situation of each country needs to be fully considered.

“31. We urge further strengthening of international cooperation in the area of health, inter alia, through exchange of best practices in the areas of health systems strengthening, access to medicines, training of health personnel, transfer of technology and production of affordable, safe, effective and good-quality medicine, and we welcome in this regard South-South, North-South and triangular cooperation and recognize that the commitment to explore opportunities for further South-South cooperation entails seeking not a substitute for but rather a complement to North-South cooperation.

“32. We stress that international cooperation and assistance, in particular external funding, need to become more predictable and should be better aligned with national priorities and channelled to recipient countries in ways that strengthen national health systems. We acknowledge the progress made on new, voluntary and innovative financing approaches and initiatives. We take note of the work and recommendations of the Leading Group on Innovative Financing for Development, as well as the findings of the High-level Task Force on Innovative International Financing for Health Systems. We acknowledge that innovative financing mechanisms should supplement, and not be a substitute for, traditional sources of finance.

“33. Although the financial and economic crisis has affected all countries, it is important to take into account the varying impacts and challenges of the crisis on the different categories of developing countries. The crisis is further endangering the achievement of their national development objectives, as well as the internationally agreed development goals, including the Millennium Development Goals. We are particularly concerned about the impact on countries in special situations, particularly least developed countries, small island developing States and landlocked developing countries, and on African countries and countries emerging from conflict. We are equally concerned about the specific development challenges faced by middle-income countries and low-income countries with vulnerable and poor populations.

“34. We recall the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property¹³ and urge States, the relevant international organizations and other relevant stakeholders to support actively its wide implementation.

“35. We reaffirm the right to use, to the full, the provisions contained in the Agreement on Trade-related Aspects of Intellectual Property Rights,¹⁴ the Doha Declaration on the Agreement on Trade-related Aspects of Intellectual Property Rights and Public Health,¹⁵ the decision of the World Trade Organization General Council of 30 August 2003 on the implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health,¹⁶ and, when formal acceptance procedures are completed, the amendment to article 31 of the Agreement, which provide flexibilities for the protection of public health, and, in particular, to promote access to medicines for all, and encourage the provision of assistance to developing countries in this regard. We also call for a broad and timely acceptance of the amendment to article 31 of the Agreement on Trade-related Aspects of Intellectual Property Rights, as proposed by the World Trade Organization General Council in its decision of 6 December 2005.¹⁷

“36. We encourage all States to apply measures and procedures for enforcing intellectual property rights in such a manner as to avoid creating barriers to the legitimate trade of medicines and to provide for safeguards against the abuse of such measures and procedures.

“37. We recognize the impact that working conditions can have on health status, health equity and general well-being. Improving employment and working conditions at global, national, and local levels, in particular to reduce exposure to work-related physical and psychosocial hazards, would help to reduce negative health effects of the environment in which people work. We emphasize the need to devise and implement

policies to ensure the health and safety of workers in line with relevant International Labour Organization standards.

“38. We further recognize that pollution and other relevant forms of environmental degradation have serious implications for public health.

“39. We reaffirm our resolve to address the adverse impact of climate change on global public health and call for successful conclusions of the intergovernmental negotiations on climate change under the United Nations Framework Convention on Climate Change.¹⁸

“40. We recognize traditional medicine as one of the resources of primary health care services which could contribute to improved health-care services leading to improved health outcomes, including those targeted in the Millennium Development Goals. We urge States, in accordance with national capacities, priorities, relevant legislation and circumstances, to respect and preserve the knowledge of traditional medicine, treatments and practices, appropriately based on the circumstances in each country, and on evidence of safety, efficacy and quality.

“41. We stress that health literacy is an important factor in ensuring significant health outcomes and in this regard, call for the development of appropriate action plans to promote health literacy.

“42. We reaffirm the need to develop, make use of, and improve national health information systems and research capacity with, as appropriate, the support of international cooperation, in order to measure the health of national populations, with disaggregated data, so that health inequities can be detected and the impact of policies on health equity measured.

“43. We are committed to promoting research and development, knowledge-sharing and provision and use of information and communications technology for health, including through facilitating affordable access by all countries, especially developing countries.

“44. We express our unwavering resolve to implement the present declaration.”

Notes

- 1 E/2009/53 and E/2009/81.
- 2 See E/2009/104, E/2009/106, E/2009/109, E/2009/102 and E/2009/88, respectively.
- 3 See E/2009/94, E/2009/93, E/2009/86, E/2009/95, E/2009/96, E/2009/111 and Corr.1 and E/2009/97, respectively.
- 4 International Health Regulations (2005), 2nd ed. (Geneva, World Health Organization, 2008).
- 5 See Commission on Social Determinants of Health, Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health (Geneva, World Health Organization, 2008).
- 6 Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995 (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.
- 7 Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.
- 8 General Assembly resolution S-23/2, annex, and resolution S-23/3, annex; and resolution S-21/2, annex.
- 9 Geneva, World Health Organization, 2003 (updated reprint 2004).
- 10 See Report of the International Conference on Primary Health Care, Alma-Ata, Kazakhstan, 6-12 September 1978 (Geneva, World Health Organization, 1978).
- 11 Pursuant to General Assembly resolution 63/33 of 26 November 2008.
- 12 A/63/539, annex.
- 13 See World Health Organization, Sixty-first World Health Assembly, Geneva, 19-24 May 2008, Resolutions and Decisions, Annexes (WHA 61/2008/REC/1), World Health Assembly resolution 61.21.
- 14 See Legal Instruments Embodying the Results of the Uruguay Round of Multilateral Trade Negotiations, done at Marrakesh on 15 April 1994 (GATT secretariat publication, Sales No. GATT/1994-7).
- 15 World Trade Organization, document WT/MIN(01)/DEC/2.
- 16 World Trade Organization, document WT/L/540 and Corr.1.
- 17 World Trade Organization, document WT/L/641.
- 18 United Nations, Treaty Series, vol. 1771, No. 30822.

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