The Global Campaign for the Health Millennium Development Goals

Countries, Agencies and Global Initiatives that so far have committed to one or several actions in the Global Campaign:

Afghanistan
Benin
Bill & Melinda Gates Foundation
Brazil
Burundi
Cambodia
Canada
Chile
Ethiopia
France
Germany
Ghana
Global Alliance for Vaccines and Immunization (GAVI)
Global Fund for AIDS, Tuberculosis and Malaria (GFATM)
Indonesia
Kenya
Liberia
Mali
Mozambique
Nepal
The Netherlands
Norway
Pakistan
Partnership for Maternal, Newborn and Child Health (PMNCH)
United Republic of Tanzania
UNAIDS – Joint United Nations Programme on HiV/AIDS
United Kingdom
United Nations Children's Fund (UNICEF)
United Nations Population Fund (UNFPA)
United States of America
World Bank (WB)
World Health Organisation (WHO)
Zambia

Building momentum – the beginning of the Campaign

Achieving the Millennium Development Goals (MDGs) on health by 2015 will be difficult. Although progress has been made, many countries are off track. There is a real danger that the appalling mortality figures for children and pregnant women will continue – unless countries, agencies, NGOs and partners renew their efforts.

This is why the Global Campaign for the Health Millennium Development Goals is being launched. It is a growing campaign encompassing several interrelated initiatives. All of them aim to accelerate progress on the health MDGs, and they have many features in common. But each also has its own approach, and focuses on a different aspect of the problem: even though some progress has been noted, why do mortality figures remain unacceptably high in most developing countries?

The Campaign is unfolding rapidly and builds on the work of the High-level Panel on UN System-wide Coherence.[1] On 5 September 2007, in London, Prime Ministers Gordon Brown of the United Kingdom and Jens Stoltenberg of Norway launched the International Health Partnership (IHP).[2] This aims to improve the co-ordination of support for national health plans, and brings together international health organisations and major donor countries, as well as developing countries.

On 26 September 2007, in New York, Jens Stoltenberg with other global leaders launched the Campaign with a special emphasis on women and children, in accordance with MDGs 4 and 5. The Campaign signals a commitment to finding better ways of achieving value for money and ensuring that the most vulnerable groups have access to essential services. The Providing for Health initiative, supported by Germany and France, will play an important role in this.

The day after the New York launch, some of the largest development-assistance donors met in Berlin to commit new finances for MDG 6 at the High-level Meeting of the second replenishment conference of the Global Fund to Fight AIDS, Tuberculosis and Malaria.[3] And in October, the Women Deliver global conference focused on the health of women, mothers and newborn babies.[4]

This is just the beginning, and new actions and new commitments will follow in the days and months ahead. A good start has been made, a lot remains to be done.

The Health Millennium Development Goals:

MDG 4 **Reduce child mortality**
Reduce by two thirds the mortality rate among children under five.

MDG 5 **Improve maternal heath**
Reduce by three quarters the maternal mortality ratio.

MDG 6 **Combat HIV/AIDS, malaria and other diseases**
Halt and begin to reverse the spread of HIV/AIDS. Halt and begin to reverse the incidence of malaria and other major diseases.

While we are half way to 2015, we are much less than half way to achieving most of the MDGs

The Millennium Development Goals – renewing the 2015 pledge

In the year 2000, at the beginning of a new millennium, the countries of the world made eight promises. These were the Millennium Development Goals (MDGs),[5] and they committed us to working together to reduce the number of people waking up each day to grinding poverty.

The Campaign is a movement for all – showing that we are taking action to get back on track.

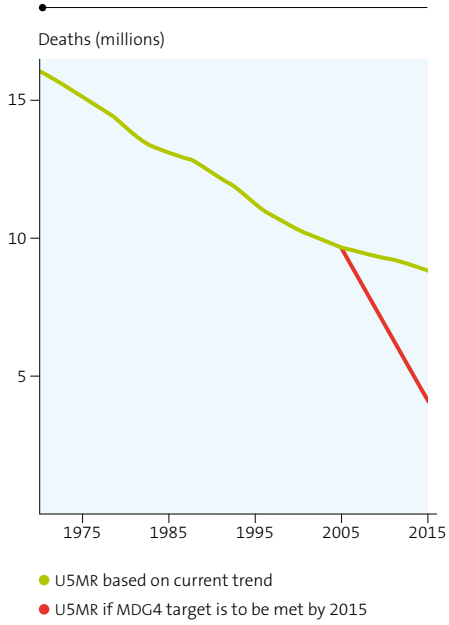
Three of those goals relate directly to health. They pledge us to reducing child mortality (MDG 4), improving women's health (MDG 5), and combating HIV/AIDS, malaria and other diseases (MDG 6).

A great deal has been achieved. Many developing countries have been making impressive efforts to improve the health services for their populations. The amount of money given in aid for improving the health of the world's poor has more than doubled to $14 billion. The number of children who die of measles each year has halved since 1999.[6] Polio, which paralysed over 350,000 children in 1988, is on the verge of being eradicated.[7] The resources flowing through the Global Alliance for Vaccines and Immunization[8] have prevented the deaths of over 2.3 million people and with the long-term predictable support for the International Finance Facility for Immunization,[9] can save an additional 10 million lives by 2015.[10] The resources invested through The Global Fund to Fight AIDS, Tuberculosis and Malaria so far have already averted 2 million deaths and is saving 110,000 lives every month.[11]

Yet, while we are half way to 2015, we are much less than half way to achieving most of the MDGs.[12]

In particular, the health MDGs are behind schedule. At the current pace, the child mortality goal will not be achieved until 2045;[13] our promise on maternal health will not be fulfilled and in some regions maternal mortality rates will be worse.[14] There are positive signs that malaria and tuberculosis can be controlled by 2015, and while we are rapidly increasing the number of people on AIDS treatment, new HIV infections are still growing fast.[11]

Unless we take action, millions of children and their mothers will suffer and die. Countries' growth and prosperity will continue to be drained by diseases. And we will break our promises to the poorest 2 billion among us. In addition to continue investing in areas such as education



This figure shows projections of under-5 mortality up to 2015 based on current trend (green line), and the reductions required to meet the MDG4 target (red line). *Source: Murray et al., The Lancet in press.*

and clean water, there is now an urgent need to focus more on the performance of health systems and the key bottle necks relating to lack of human resources, infrastructure and sustainable financing, as declared also recently by the G8 summit in Heiligendamm.

The Global Campaign for the Health MDGs

Everyone agrees that action is needed. Countries and international partners have mobilised to develop an effective response to the MDGs. What is missing is a focus for political action at the highest level.

That is what the Global Campaign for the Health MDGs is – a call to renew our commitment to achieving the Millennium Development Goals on health by 2015.

The Campaign is a movement for all – which donors, international agencies and stakeholders can join – showing that we are taking action to get back on track by the end of 2010 and achieve the health MDGs by 2015.

So, what are the principles of this Campaign?

- **Countries set their own priorities**
  Countries decide their own health priorities, and create national health plans to achieve them. Aid agencies should co-ordinate their work to fit and support these plans.

- **Agencies give aid without adding to countries' administrative burdens**
  Aid agencies shouldn't add to the amount of reporting, information collecting and administration that governments and health workers have to do. In fact, this burden should be lightened. We should avoid creating new institutions that make the way aid is given (the "aid architecture") more complex.

- **Everyone ensures that money is well spent**
  More attention should be given to results, so that the money spent is linked to the results achieved – in work on women's and children's health, HIV/AIDS, tuberculosis, and malaria. This will ensure that neglected issues and groups get the attention they need.

- **Agencies help to develop the country's whole health system**
  Aid agencies should work in ways that strengthen the country's health system as a whole. That means increasing the flexibility of funding so countries can build up local facilities, increase the number of health professionals and ensure that enough health workers and medicines are in place where they are needed. It also means making and keeping long-term commitments.

- **All partners work in a transparent and accountable way**
  Openness benefits everyone: the voters whose taxes are spent on development work, the contributors to charities, and the people in the countries being helped. They all have a vested interest in knowing that money is being spent – and healthcare provided – in a fair, open, honest and effective way. Independent evaluation processes will be critical to this principle and ensure effective use of resources.

In short, we must be more effective, better coordinated, invest more and ensure that we reach the poorest and weakest.

If we can all sign up to these principles – as many have already done in signing up to the Paris Declaration on Aid Effectiveness (2005) and the International Health Partnership Global Compact[2] – we will have a real chance of meeting the health MDGs. And that will mean we have helped to create a fairer world for everyone.

If we can all sign up to the principles of the Campaign,we will have a real chance of meeting the health MDGs.

A new way
of doing business
to achieve
better results

What will be done?

A lot of good work is already going on. The countries receiving aid are at the core of this work, supported by partners and partnerships that provide technical and funding assistance. The Campaign will help to find ways of making that work more effective, giving a better chance of achieving the health MDGs by 2015.

Action will focus on three areas:

1. **We will respect country leadership:** Ongoing international health initiatives will cooperate better, simplify procedures to respond to country partners and agree on priorities squarely based on each developing country's national health development plans and budgets. Everyone, development partners, international agencies, civil society and country governments will work together to support their development. While disease-focused activities are achieving impact on the ground, health systems as a whole will be supported and strengthened, so that improvements become sustainable and reach across all parts of its population.

2. **We will do more for mothers and their children:** In addition to sustaining and accelerating efforts on AIDS, TB and malaria, we must simply do more for women and children. Maternal, newborn and child health does not yet get the priority it needs, neither by those who provide assistance nor by those who fund the health services in developing countries. It is unacceptable that almost 10 million children die each year largely from preventable causes and that each year more than 500,000 women die from treatable or preventable complications of pregnancy and childbirth. Improving newborn health will be essential to meet MDG 4 and will contribute substantially to meeting MDG 5.[14]

3. **We will invest more resources:** For all these efforts to succeed, more resources will be raised, including innovative sources of financing, and invested in a more effective way to produce results. While both international assistance and many developing countries have increased their investments in health, we remain far short of what is needed to achieve our goals.[15] Health systems need longer-term and more predictable financing. Success will be measured through a reduction in mortality, and funding will be provided based on performance. More work is also needed to develop sustainable financing mechanisms that give access to the poorest, including sound risk-pooling approaches relevant to the country context.

Success will be measured through a reduction in mortality, and funding will be provided based on performance.

The IHP global compact represents a commitment to a new and better way of working.

So far, five actions are being taken that support the Campaign's principles. The Campaign is being joined by governments, agencies and donors that are ready to throw their support behind its goals.

1 – Providing a framework for co-ordinating aid, and reducing the burdens that go with it

The International Health Partnership (IHP)[2]

There are many different organisations involved in providing aid, but they often fail to take account of one another. One result of this lack of co-ordination is the reporting demands and requirements on how each entity's money is being spent, and the effect it is having.

Because agencies and initiatives ask for different information in different forms, collecting and delivering it takes up a great deal of time for health workers, civil servants and other valuable people – and this loss of time means that aid is less effective than it could be. For example, doctors spend time on reporting rather than treating patients.

How the IHP will work – a global compact

The IHP aims to support governments to achieve health results by helping aid agencies work together more effectively, reducing wasteful duplication and ensuring that the money achieves more. The IHP global compact, signed in London on 5 September by leaders, donors, agencies and countries, represents a commitment to a new and better way of working – co-ordinating their work to support countries' national health plans.

The compact will involve commitments from those who receive aid as well as those who provide it. It is important that governments listen to their own citizens in preparing their plans, and that they take account of citizens' views about its performance. The providers of aid need to know that their efforts are supporting a well designed national health plan that will genuinely improve people's health. They need to know that the plans support their efforts – whether on AIDS or maternal health – before they support it. Governments will be accountable for achieving results.

Country agreements

Work will begin with a first wave of countries to decide how to put the commitments into practice, and to agree on measurable targets – drawn from current plans and national priorities, so avoiding creating more administration. These targets will be set down between governments and partners in a memorandum of understanding, a code of conduct or a separate country compact.

Each government and their partners will consult and work together to determine how the global compact will work locally. This will help identify the sorts of changes needed in the way agencies and partners work to more effectively support national health plans.

Because national plans will be strengthened and monitored, the results they produce will be validated. This information can be presented in a way that all aid agencies will accept, which will reduce the burden of reporting currently borne by valuable workers in developing countries. The information countries provide can then be aggregated for global and regional uses.

The IHP has broad support from bilateral partners including the UK (lead promoter), Norway, the Netherlands, Germany, Canada and France, as well as multilateral agencies including the WHO, UNAIDS, UNICEF, UNFPA, the World Bank, the Global Fund for AIDS, TB and Malaria and the GAVI Alliance.

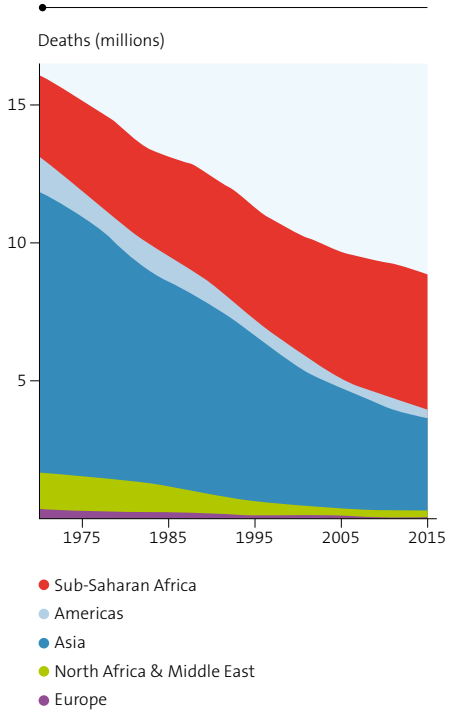
Countries that will participate in the first wave of implementation include Ethiopia, Kenya, Zambia, Mozambique, Burundi, Nepal, Cambodia and Mali. And this group will grow as new countries join.

2 – Making sure women and children receive priority

Women and children continue to get the worst deal in health. They benefit least from health services, even though they are often most in need of them.[16]

In addition, women and children often lack a voice – a means of expressing their opinions – which means that there is little pressure on governments to provide services for them. They need to be given a strong and concerted voice – a combination of others advocating

Each government and their partners will consult and work together to determine how the global compact will work locally.



This figure shows the number of under-5 deaths by region since 1970 and projected to 2015. Over this 35 year period, the number of children dying each year in the world will decrease from over 16 million to below 10 million. Yet based on current trends, the number of children dying in sub-Saharan Africa is actually increasing.

Source: Murray et al., The Lancet in press.

action on their behalf, and enabling them to raise their own voices – in order to call for the services they need and hold governments to account.[17]

Because of this the number of women who die from pregnancy-related causes each year is still over 500,000 – the same number as 20 years ago. And for every woman who dies giving birth, another 30 suffer debilitating injuries.[18] The same lack of local services is one of the main reasons for the fact that, of the ten million children who die before their fifth birthday, and almost half are less than one month old.[19]

Vertical, disease specific initiatives can deliver impressive results, but do not necessarily contribute to comprehensive health and nutrition services for women and children.[14] Despite the overall increase in aid funding for health, a large portion of that increase has gone to specific diseases, while funding for maternal, neonatal and child health has not increased significantly, and is not sufficient to achieve MDG 4 and 5.[15]

A network of heads of state

Political commitment is needed at the highest level. Only this will make it a government priority to protect and promote the health and wellbeing of all women and children, pushing through the necessary changes, and allocating resources appropriately. Heads of state and government from a number of countries have joined in a "Network of Global Leaders" to provide the necessary leadership and momentum. Currently, these countries include Norway, Brazil, Chile, Indonesia, Mozambique, Pakistan, Tanzania and the UK. In order to keep up the momentum they will be regularly briefed on progress relating to Women and Children's health. The briefs will be informed by independent reviews.

A consistent long-term advocacy drive

To keep momentum both in the North and the South a dedicated advocacy and communications drive is being developed: "Deliver Now for Women & Children". Coordinated by the Partnership for Maternal, Newborn & Child Health[20] – a global network of more than 180 organizations – the advocacy drive will strengthen civic activism to increase

demand for maternal and child health services, hold political leaders accountable and committed to deliver in investment and expansion of maternal and child health services, strengthen the capacity of the media, and enable scaling up of health services to reduce maternal, newborn and child mortality. The drive will promote solutions in line with the principles of the Global Campaign.

Delivering maternal, newborn and child health services

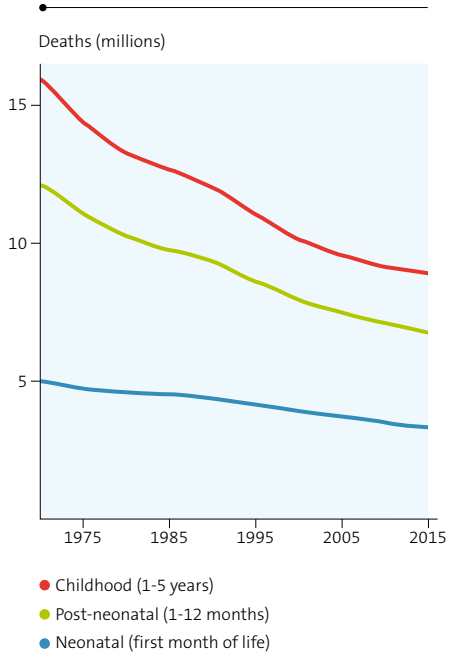
There are good estimates of what it costs to help women and children.[21] This action will identify where the gaps[22] are between what is needed and what is being done. Work can then be co-ordinated, as a result of the other actions detailed here, to close these gaps. One such framework is the African Union's strategy for child survival, which has widespread support including from UNICEF, WHO and the World Bank, among others.

The majority of maternal and newborn deaths could be prevented if women had access to cost-effective interventions and health care during pregnancy, childbirth and after delivery as well as access to family planning services.[23]

Today, only half of the world's women have the care of a skilled professional when giving birth,[14] and only one in ten of HIV-positive pregnant women in low- and middle-income countries receive antiretroviral prophylaxis to prevent HIV transmission to their child.[24] The greatest risk of death is at the very beginning of life: three million newborns die each year within one week of birth, and up to two million babies die on their first day of life.[19]

To achieve progress, investments in health systems and human resources will need to focus on women, newborns and children in order to provide sustainable services, increase demand and address behavioural factors such as promotion of breastfeeding.

Agencies and civil society need to have a shared agenda in order to better support countries to deliver an essential package of interventions for women, newborns and children.



This figure shows that over the period 1970 to 2005 and projected to 2015 progress on reducing post-neonatal mortality is much greater than for reducing neonatal mortality. Progress on neonatal mortality may be slower because it requires more complex health system support for birth and post-natal care and because less priority has been given to newborn and maternal health.

Source: Murray et al., The Lancet in press.

Simple and affordable solutions exist for many of the most common causes of child and maternal deaths.

3 – Extending essential services to reach more people, with a focus on outreach at the community level

The problem

In many of the poorest countries a majority of children and women with life-threatening disease are not able to get lifesaving medical services. Simple and affordable solutions exist for many of the most common causes of child and maternal deaths. Without strengthening and extending health services to deliver these solutions to those that need them most little progress will be made.

A common results-based approach

Canada in partnership with Norway, UNICEF, WHO, the World Bank, the Bill and Melinda Gates Foundation and USA are working together to develop an innovative approach – to be launched shortly – to strengthen health systems in order to achieve sustainable results, and ensure women and children receive essential health services. Critical to this approach are both capacity building and support to the health system to tackle weaknesses in health services (such as shortages of skilled workers, medicines or other resources) at the front line.

In addressing these weaknesses there is a need for assistance that builds increased and sustained access to proven cost-effective and high impact services for those who need it most. Depending on the country services to be scaled up interventions may include: community based delivery of vitamin A supplements, and long -lasting insecticide-treated bednets for mothers and children, treatment for malaria, pneumonia and diarrheal disease, breastfeeding counselling, immunizations for mothers and children, and prevention of mother to child transmission of HIV.

4 – Finding the most effective ways of spending money

Current funding mechanisms do not always help governments achieve health results because of restrictions, for example, that funds be used only within defined disease control programs or for specified activities or by specified groups. When the disease goal requires broader systems fixes or when the health provider doesn't perform, the government does not always have the flexibility or motivation to change how funds are used.

The objective of Innovative Results-based financing is to test out and evaluate new ways of financing to better achieve our health goals. The aim is to get the greatest value for money spent. By linking funding to measurable results, governments and communities have increased motivation and capacity to achieve results – or fix whatever problems are impeding them. In results-based financing, money depends on real improvements for the health of poor people.

Responding to incentives

The evidence suggests that small financial incentives targeted at the right level, such as those described above, are enough to change behaviour significantly and achieve results. Attention to results means those with the power to make change quickly become aware of problems and have the motivation to take action, for example by moving funds to wherever they can be used more effectively. Of course, countries still need predictable, long-term funding. Through results-based financing they can be assured of funding-- what changes is how it is spent– unless results are good.

There are many ways of implementing results-based financing, and countries will be able to design what suits their circumstances best. Different options will be tested and expanded as governments and partners learn what works. Learning by doing is an essential component of this effort.

Importantly, results-based financing would still allow special-interest groups to donate to achieve specific outcomes – such as fighting a specific disease – but without having to separately track their money. Funds from different partners can also be pooled to support the national health plan, with an eye on how well it delivers results. In this way, Innovative Result-Based Financing will contribute to the work of the International Health Partnership. It will also have a special emphasis on outcomes for women and children.

A number of countries have expressed interest developing this approach, including Norway (the lead promoter), Canada and the UK, as well as global funds: GFATM, GAVI, and the Bill and Melinda Gates Foundation. The World Bank will coordinate this work. This innovative financing approach may be linked to the Bank's core development

How successes have been achieved with results-based financing

Births are more likely to go well if there is professional care, advice and equipment on-hand. In India, a government scheme directed at mothers living under the poverty line in the poorest states motivated 80% of them to choose to give birth in health facilities – up from just 20% the year before the scheme began.[25] This happened because the scheme subsidised the cost of transport to and from the clinic for mothers, as well as providing incentives for the health workers involved.

In Rwanda, the use of bed nets for children increased from 4% to 70% over three years, producing a dramatic reduction in malaria rates and emptying beds in paediatric wards. This happened because the amount of money the government gives municipalities to spend on health depends on how many children sleep under mosquito nets.

GAVI pays a country US$20 for each additional child immunised. An independent review in the Lancet, one of the world's most respected medical journals, found that the scheme led to many more children being vaccinated in the countries that had previously performed least well.[8/10]

In results-based financing, money depends on real improvements for the health of poor people.

financing through IDA.[26] We are exploring interest among partner countries in participating in a first wave, testing and developing these approaches.

5 – Providing for Health Initiative

Promoted by Germany and France this initiative has been supported by the G8[27] under the German Presidency. Its main objective is to improve sustainable and equitable financing structures of health systems to enhance access to health services of adequate quality in developing countries and to protect people from the adverse financial consequences of high out-of-pocket payment.

Overall, if health care systems in poor countries are not reinforced, notably through establishing social health protection systems, all of efforts to fight contagious and non-contagious diseases in these countries may prove to be in vain.

In sub-Saharan Africa, spending on health is US $30 per person per year, nearly 100 times less than in the OECD countries.[28] This amount is insufficient to cover the most essential needs in this field. Moreover, more than half of health spending is borne by households in the form of direct payment at the point of consumption. Because of this payment method, disease and the spending it generates cause 100 million people to fall below the poverty line every year as a result of one member of the household experiencing dramatic expenditures due to a serious health event.

Out of pocket spending for health financing through direct payment generates profound inequities in the health systems of the overwhelming majority of developing countries. Moreover, access to health services is always lower for women, young people and households living below the poverty line.[14] The poorest segments of the population are devoting a proportion of their income to health spending significantly larger than those in the higher income groups.

To date, the policies carried out with the support of the international organisations to improve social health protection coverage in developing countries have failed to achieve the expected results. Free services in the public health sector have had to contend with the need for sound

management of public finance and have failed, in many countries, to prevent continued or even exacerbated inequality in health and access to health services, to the detriment of the poor. Similarly, policies relating to health cost recovery, launched 1987 in the Bamako Initiative,[30] which promotes direct participation of users in the financing of health services, have not made it possible, despite some successes at local level, to provide long-term financing of primary health centres or to reduce inequalities in access to services.

Macro-economic studies have confirmed that better health is correlated with stronger economic growth. Investing in health promotes pro-poor growth. Thus, if the recommendations of the WHO Commission on Macroeconomics and Health were implemented, life expectancy in developing countries would be raised from 59 years at present to 68 years, which, they claim, would increase growth in these countries by 0.5% per year.[29]

The way forward

A growing international consensus, reflected in the conclusions of the Berlin (2005) and Paris Conferences (2007), is now emerging in favour of developing ways to improve the financing and effectiveness of social health protection coverage in developing countries.[31] This aims at seeking the best combination of public intervention on the one hand and the establishment of mechanisms for social protection in health (e.g. through social or mutual insurance schemes or taxed-based mechanisms etc). A number of countries have introduced policies aimed at building a universal social health insurance system. Others have experimented with a variety of mutual health insurance schemes, ranging from community-based insurance to private non-profit insurance and the private voluntary insurance market. These experiments will be fully assessed before pursued for scale up in other countries.

The day
of our birth
is the most
critical day

How will it all work?

Because the Campaign's principles place so much emphasis on working with countries to meet their national health plan goals and on co-ordinating efforts from different sources, the different actions described above will work differently in each country – in a planned and complementary way, but specific to the circumstances of the country. These actions will be tailored to each country and included within its national health plan. Partners will be committed to coordinated action around the national health plan and to engage in "one conversation" with governments.

Development partners will closely coordinate their work with all stakeholders facilitated by the newly established Heads of Health Agencies (the "Health 8" – WHO, the World Bank, UNICEF, UNFPA, UNAIDS, GAVI, GFTAM, and the Bill and Melinda Gates Foundation).

The annual review of progress nationally and globally at the highest level as outlined by IHP will be used across the different actions in the Campaign for mutual accountability, monitoring progress towards the health MDGs, and addressing gaps. Intermediate goals will be aggregated based on individual country plans.

First wave countries for the five actions will be distinct, but with overlaps. In the scale-up phase, they are foreseen to be implemented jointly.

To maintain political momentum and hold all partners to account on performance and progress:

- Annual political reviews of progress on health MDGs will be organised by the International Health Partnership
- A "Status Now" conference focusing on women and children will be organized in late 2010 to take stock and renew the Campaign if catch-up has not been achieved.

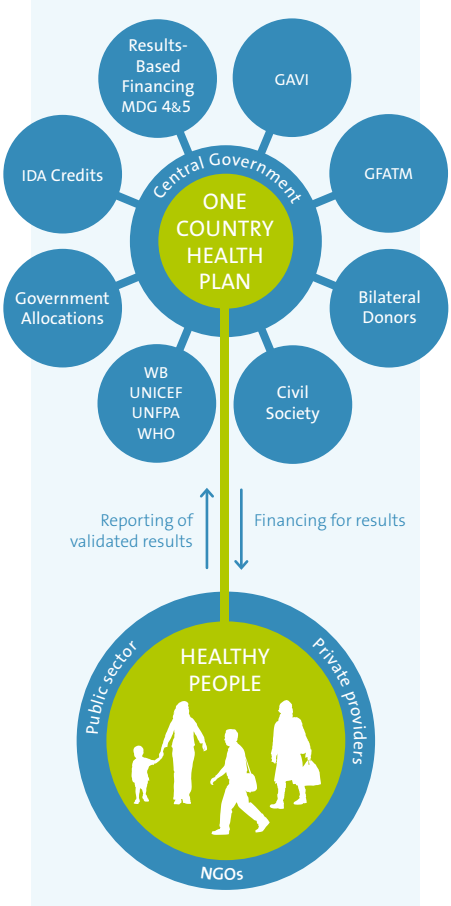
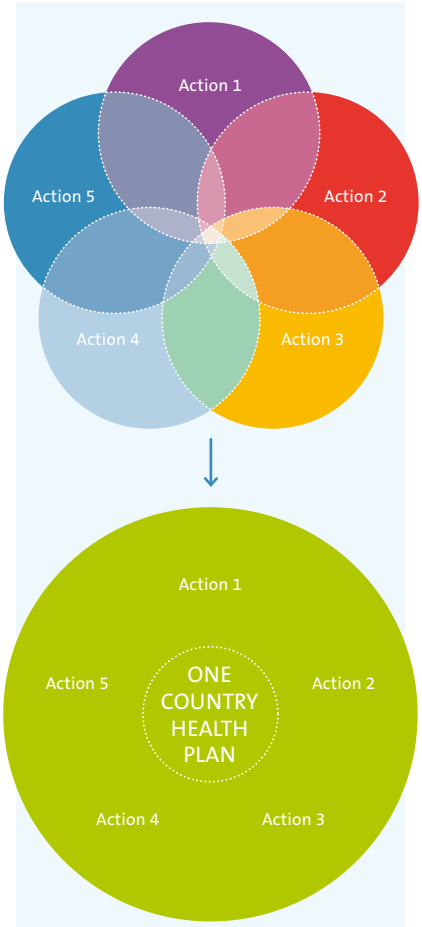


Illustration of the relationship between the different actions in the context of national inclusive ownership. Action 1 (IHP) primarily operates at central level around the one country health plan (upper part of the figure); action 3 focuses on processes that need to happen at local level (lower part of the figure); actions 4 and 5 promote effective spending and health delivery – and action 2 provides an additional focus and mobilization for women and children.



The figure illustrates how distinct but overlapping actions in the start-up phase will evolve into integrated solutions in the scale-up phase. Success depends on countries taking the leadership role around their national health plan.

The phases of the work for current Campaign actions

Each of the actions – and their timing – will work differently, but it is anticipated that each will follow a common sequence of phases. Phasing will depend on agreement and progress at country level, with the intention of moving as quickly as possible.

The preparation and design phase will involve first-wave countries working with agencies to develop plans for the actions. Indicators of progress will also be selected and developed during this phase.

The implementation phase for first-wave countries will be well underway by early 2008, with clear plans in place and agreed arrangements – embodied in country-level compacts – for co-ordinating the activities of the various partners.

Monitoring and review will examine the results of actions in first-wave countries and identify lessons for scale-up by 2009.

Scale-up and expansion will, depending on progress and lessons learned in first-wave countries, involve actions being rolled out more widely between 2010-2015.

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